入院番號 No.	240	診斷軍医名 NAME OF DIAGNOSING DOCTOR		Gunn	
部隊号 UNIT.	12th C.R. R.A.	國籍 NATIONALITY		階級氏名 RANK & NAME	Gunner Cripps, John
病名 DISEASE	1.Dysentery 2.Pneumonia	入院月日 DATE ADMITTED	1/7/42	退院月日 DATE DISCHARGED	Died 8/7/42

月日 DATE	治方 TREATMENT	摘要 REMARK
	Reported sick about 4 days, headache & fever ~~a~~v Abd. distress - Diarrhoea began then. No pain at beginning but has pain now. Vomited several times. R.O.H. No blood or mucus. Stool porridgey. No previous history of dysentery. Malaria: nil. Tongue sl. furred. Conjunctivae - isteric Liver edge just palpable.	
3/7	Has fair amount of abd. pain especially down left side today & in loin. Icterus is fading slightly.	
4/7	Complained of severe abd. pain during night. pass blood - meloena. 2.cc. Pulse good. No marked rise in T. or P. condition good.	
5/7	Icterus fading - Slept well. No Pain. abd. almost normal. T. & P. normal.	
7/7	T.101. Chest full of rales etc. Cough ++	
8/7	T.104 Chest full of rales . Color v.poor. Pulse full good quality. No edema present. Had ~~3~~ mist 3XD. Is completely senseless & lax. the pupils are small & do not react to light.	
	• Died 1430	
	(Signed) W. Gunn	

20200

Service - 3 yrs.
Age 21 years

No.	16075		NAME OF DIAGNOSING DOCTOR		Captain T.P. Sundram, I.M.S.
UNIT	5/7 R. R.	NATIONALITY	Indian	RANK NAME	Sepoy Bansha Bahadur Singh
NATURE OF DISEASE	Broncho-pneumonia	DATE ADMITTED		DATE DISCHARGED	Died (1.10 a.m.) 9,7.42.

DATE	TREATMENT	REMARKS
28.6.42.	Trianon one ampule intravenously given Tablets trianon 4 at 4.p.m. and 4 at 8 p.m. Patient arrived in a very bad state - semi conscious	
29.6.42	Trianon tablets 4 Thrice daily Boro-Glycerine to apply (mouth) Condition the same.	
30.6.42	Quinine Bi-hydrochlore - grs 7½ (I.M.)	
1.7.42	Chloroform - M 20) Oil china podium-M 15) one course given Liq. Paraffin - ½ oz Enema simplex- 1 Pint given at 9 a.m. Mist Quinine -oz at 8 am. & oz at 10 p.m. given . Condition the same.	
2.7.42	Enema simplex - oi given at 9 a.m. Mist quinine oz given at 12 noon & oz at 4 pm. Condition the same.	
6.7.42	Quinine Bihydrochlore - grs 10 I.M. given at 9 p.m. Condition worse.	
7.7.42	Quinine Bihydrochlore - grs 10 given at 9.30 a.m. Condition worse.	
8.7.42	Cold sponging & Iced rectal saline given at 4 p.m. Condition grave.	
9.7.42	Patient expired at 1.10 a.m.	

Signed (T.P. Sundram)
Capt. IMS.

(L.W. Ashton-Rose)
Major
No.3 W. of W. Hospital

E8203

No.	257	NAME OF DIAGNOSING DOCTOR		Gunn	
UNIT	Midsx.	NATIONALITY	British	RANK + NAME	Pte. Devine, Cyril
DISEASE	Dysentery B.	DATE ADMITTED	8/7/42	DATE DISCHARGED	Died 10/7/42

DATE	TREATMENT		
	Reported sick a week ago c abd. pain, diarrhoea, headache, fever, nausea. Now has some slight pain, motions loose - blood & mucus, V.C. teneamus, some headache. No appetite. No other complaints. Malaria: Feb. '41. Tongue furred & dry. Abd: marked tenderness in all areas.	S/B	Water Only
10/7	101^4 120. B.o.18. - Some blood & mucus still. Feels better. - 1600 Patients pulse v.poor & v. restless. constantly on b. pan - no blood or mucus. 2100 Sl. better - he says but almost pulseless. Condition poor. 23.20 Patient died. WG.		

No. 2 Hospital 12/7/42

POST MORTEM - Pte. DEVINE, Cyril. Middlesex

External Appearance:- Well-built male showing no signs of malnutrition. No external evidence of wounds or injury. Old healed hernia scar left inguinal region and well healed appendicectomy scar in right lower quadrant of abdomen. External genitalia normal. P.M. Lividity and rigor mortis present.

Internal Examination:- Brain not examined.

Chest:- (1) Lungs - Pleural cavities clear of fluid. Both lungs congested. No adhesions. No evidence of consolidation.

(2) Heart - Pericardial cavity normal. No increase in amount of fluid present. Heart normal size. The mitral valve showed old nodular thickening of edges of cusps. Other valves normal. Slight degree of atheoma of aorta. Endocardial surface normal. Myocardium appeared normal.

Abdomen:- (1) Liver - Normal in appearace except for irregular scattered yellow areas. These were firm and only extended about 2 m.m. below the surface. It suggested fatty degeneration. Gall bladder well filled - no stones.

(2) Spleen - Normal size and shape and appearance on section. Capsule stripped easily.

(3) Both adrenal glands appeared normal.

(4) Kidneys - Normal in size and appearance. Right pelvis contained a small amount of thin creamy pustular fluid.

(5) Bladder - Normal. Contained about 100 c.c. of normal clear urine.

(6) Stomach - Mucus membrance showed P.M. ulceration; otherwise normal.

(7) Intestines - Small intestine normal appearance except for last 8 inches of ileum. Here there

was edema of muscle wall and congestion of mucus membrane with ulceration in scattered areas. It was recent in appearance.

The caecum and colon as far as the splenic flexure was thickened due to edema of muscle coats and congestion of mucosa and submucosa. The mucus surface was dark green with tinges or red. The normal appearance was lost in a coarse roughness of the whole surface resembling very coarse sand paper. A few small ulcers were present. This acute condition improved toward the sigmoid and rectum. The appearance was that of acute bacillary dysentery without ulceration.

A firm band of adhesions fixed the caecum to the anterior peritoneal surface at the site of the appendicectomy.

The mesenteric glands were haemorrhagic but not markedly enlarged and normal in consistency on section.

Casue of Death:-

1. Bacillary Dysentery
2. Toxemia and Myocardial Failure.

(Sgd) W. Gunn

Surgeon Lt. Cmdr. R.N.

Case No. 404

	No.	P. No. 110 5280	NAME OF DIAGNOSING DOCTOR.		Captain B.I. Evans I.M.S. Captain T.P. Sundram I.M.S.	
Age: 22 yrs. Service: 3 years	UNIT	24th Battery 12th C.R. R.A.	NATIONALITY	Indian	RANK + NAME	Gunner Ghulam Mohd
	DISEASE	Acute Gastro-Enteritis	DATE ADMITTED	15.6.42	DATE DISCHARGED	Died 10$\frac{7}{42}$ at 5.55 p.m.

Date: 1[illegible]42 Weight: 95 lbs.	DATE	TREATMENT
	15.6.42.	Received on a stretcher complaining of vomiting, anoraxia, great prostration, and some times haemoptysis. Dinolum as stated=one month Temp: 99.6 F. Pulse rate 110 p.m. Resp. 24.p.m. No. of stools in 24 hrs=5 emaciation marked. Cough ++ Bronchial breathing with increased V.F.+ V.R. in scapular region Rt. side. Sputum pr TB No. TB sen For observation Stools pr Ova. No OVa sen
		R. ol. Morrhuae m 10 T.ds. Very dehydrated Subcutaneous Saline oz.30 stat. Lung. Some consolidation in the middle zone of the rt. lung. Few crepitation Sputum for exam? NoTB sen Stools No ova sen
	17$\frac{6}{42}$	1 Pt. Normal saline given SC Ol. Morrhuae X Tds. Mist. Calcium Lactate oz Tds. } Blood pr M.P negative
	20.6.42	Persistent vomiting since last night. Dehydration again marked.
	22.6.42	Calomel 1/3 gr soda Bicarb 15 gr & Mag.sulph 30 grs. Tds. and Rectal saline 2 Pts Bleeding from gums,with foul smelling ulcers under the tongue, lips, and oral cavity. Gargles frequently.
	26.6.42	Mist. Bismuth ℥i Tds. & citex ltibs 2 Tds.
	1.7.42	Stomach lavaged with soda Bicarb ℥ii in 0.i Ulcerative stomatitis + + with diarrhoea and Prupuse haemorrhagia. Frequent gargles Citex ltibs one tds. mist. saline ℥i every hrs. for 6 doses
	8.7.42.	Trianon 10 cc. intravenously
	9.7.42	Dehydration marked. Patient unresponsive to surroundings. Subcutaneous normal saline with calcium chloride gr 1 in 0.1½pints given.
	10.7.42	Patient sinking. 5 p.m. Hiccough started. Pat ient died at 5.55 p.m.

T.P. Sundram
Captain IMS.

L.W.Ashton-Rose
Major
Comdg. No.3 P.OF W. Hospital

Case No.		Name of diagnosing Dr.	Rodrigues.A.M.		
Unit	R.Engineers.	Nationality	SCOT	Rank and Name	Sapper Faughnan.J.
Name of Disease	Dysentery	Date admitted	12.7.42	Date of death	13.7.42

Date	Treatment	Remark
12/7	Oleum Ricini given on admission. Blood & mucus in stool. Seen by Dr. Price in the evening-complaining of shortness of breath, but no signs found in chest to account for same. Pulse 82. Temp. Normal 9 p.m. ¼gr. Morphia given hypodermically. Profuse sweating, respiration strained, pulse 84, colour good. 13/7 2 a.m. Patient in distress, cold sweat, difficulty in breathing even when propped up, pulse 85 chest clear, air entry good. ¼ gr. morphia & 1/100 gr. Atropine given hypodermically. Condition unchanged in the morning. Bismuth salicylate 5 grs. 6-hourly 12 p.m. 1 c.c. Coramine given by injection. 1 p.m. seen by Dr. Price - respiration easier. 2 p.m. unchanged condition, pulse 90. 2.30 p.m. died. Lieut. H.K.V.D.C.	

Report on Post-mortem examination made at 7.30. p.m.

General appearances. Body well developed and fairly well nourished. Rigor mortis, P.M. lividity and slight cyanosis present.

CHEST. Pleurae healthy except for a few small adhesions (old) on the left diaphragmatic surface. The lungs both showed old, healed tubercul lesions at their apices but were otherwise healthy. Trachea healthy. The pericardial sac was healthy except for petechial haemorrhages on the visceral pericardium covering the posterior aspect of the heart. The Left Coronary Artery showed some atheroma and occlusion by a thrombus. Both sides of the heart were dilated. The endocardium was healthy except for old rheumatic thickening of the mitral valve. The aortic valve and aorta were healthy.

ABDOMEN. Except for acute congestion of the intestines the abdominal contents were healthy.

CRANIUM & its contents were not examined.

SUMMARY. I am of the opinion that death was due to
CORONARY OCCLUSION
DYSENTERY (BACILLARY TYPE).

J.S. Allan Gray
Major. R.A.M.C.

Shamshuipo P.O.W.Camp
13th. July 1942

80200

CASE NO. 430

No.	14697		NAME OF DIAGNOSING DOCTOR		Jem. N.B. Pasary I.M.D.
UNIT	5/7 R.R.	NATIONALITY	Indian	RANK NAME	Sepoy Jai Singh
NAME OF DISEASE	Acute Enteritis	DATE ADMITTED	28.6.42	DATE DISCHARGED	DIED 14.7.42.

DATE	TREATMENT		REMARK
28.6.42	Fever, Vomiting after food, swelling of the abdomen progressive weakness duration 1½ months.	7.7.42 and Milk- ½ bottle	
	Oedema over tibae + ankles + + fluid in the peritoneum & pleural cavity + + signs of heart failure + Loss of appetite + +	8.7.42 Milk - ½ bottle 9.7.42 Milk - ½ bottle 10.7.42 Milk - ½ bottle	
	Thimine - ½ c.c. Sub.For 3 days.	11.7.42 Milk - ½ bottle	
	Mist Saline - ℥i (stat).	12.7.42 Milk - 1 bottle	
	Stools reveal E. H. (Vegetative Form) Mist Pot citrus et digitalis ℥i TDs.	13.7.42 Milk - 1 bottle	
30.6.42	Emetine Hydrochlore - gr 1 (sub) for 6 days Followed by 4 days rest.	14.7.42 Milk - 1 bottle	
10.7.42	Emetine Hydrochlore - gr 1 (sub) every day The pt. complained of oppression the the chest & halpitation. Stop emetine. Mist pot citrus et Tr Digitalis ℥i TDS. Stools - 8 times Lusil Tablets - 4 B. W.c		
11.7.42	Mist Bismuth - ℥i TDs. Lusil Tablets - 4 in the morning.		
14.7.42	Mist Pot citrus et tr Digitalis - ℥i Spirit ammon Aromate - mx Tds. Calonasin - 2 cc (sub). Patient expired at 11.p.m. N.B. Pasary Jem. I.M.D.		

L.W. Ashton-Rose
Major I.M.S.

Comdg. No.3 P.Of.W. Hospital.

Case No.		Name of degnosing Dr	Rodrigues.A.M.		
Unit	Royal Scots	Nationality	Scot	Rank and Name	Pte Forrester. John
Name of Disease	Enteritis	Date admitted	10.7.42	Date of Death	15.7.42

Date	Treatment	Remark
	Oleum Ricini given on admission.Stools--Blood & mucus.Temp.1 02F Pulse 95. Magnesium Sulphate 8 gms. 6-hourly.25 stools passed for the day. Kaolin given 6-hourly in 8gms. doses. Pain in abdomen increased and stools still blood-stained and with mucus Temp.100 F.Pulse 90. Passed a better night,so Bismuth Salicylate Grs.5 given. Condition deteriorated in the afternoon.Temp.101 F..Patient restless. Morphia ¼ gr.givenat night 9 p.m. Patient became slightly delirious and Morphia ¼gr.and coramine 1c.c. given,in the early hours of the morning. Patient semi-comatose and coramine 1 c.c. given 7.30 p.m.Temp.103 F Pulse 100 Condition remained unchanged,patient moribund,pulseless at wrist. Coramine given at 11a.m.and 5p.m. and morphia ¼ gr. in between. Died 8.30 p.m. Authorigues Lieut.H.K.V.D.C.	

CASE NO. 280

NO.	280		NAME OF DIAGNOSING DOCTOR		Captain A.H.R.Coombes R.A.M.C.
UNIT	12th C. Regt. R.A.	NATIONALITY	British	RANK NAME	WEAVER, B. Gunner
NAME OF DISEASE	Septicaemia and ? Diphtheria	DATE ADMITTED	4/7/42	DATE DISCHARGED	18/7/42 Died

DATE	TREATMENT	REMARK
4/7/42.	Admitted with multiple skin sores and dermatitis of scrotum Treated by "Eusol" Dressings twice daily.	Condition Unimproved
9/7/42	Eusol Dressings. Dagenan tabs. 6.	
10/7/42	- Condition not improved ---- Transferred to Skin Hospital	
14/7/42	Readmitted from Skin hospital with tonsillitis ? Diphtheria and extensive infection of perineum Dagenan 6 tabs - Eusol Dressings and Carbolic 1 in 100 gargles 5 time daily.	Skin condition worse. Tonsillitis?- Diphtheria
15/7	Dagenan 8 tabs - Gargles and Eusol	Condition worse
16/7	Dagenan 8 tabls- Gargles and Eusol	Condition still becoming worse
17/7	Dagenan 8 tabs - Gargles andEusol	Condition much worse.
18/7	Eusol Dressing Coramine 3.4 cc. (2 ampoules) at 10.50 Transferred to Hong Kong Prisoners of War Camp Hospital No.2.	Condition moribund
18/7	Admitted to St. Teresa's Hospital, in moribund condition, haemorrhage from and cold & very shocked. Died about 5 minutes after admission.	

W.D.G.

No.2 Hospital 18/7/42.

POST MORTEM - Gnr. WEAVER, B. 12th C.R.,R.A.

History. 4/7/42. Admitted S/Poo Hospital with multiple skin sores and dermatitis of scrotum - treated with Eusol and Sulphapyridine.

14/7/42. ? Diphtheris - scrotal infection extensive. Treated with Eusol and Sulphapyridine - No improvement.

18/7/42. Condition critical - transferred in moribund state to No.2 Hospital for Prisoners of War.

POST MORTEM NOTES.

External Examination:- Well built young male, no evidence of malnutrition. The skin was broken by sores over limbs, neck and back. These sores were about 3 - 5 cm. in diameter, slightly raised, hard, and had a dark haemorrhagic base. The epidermis over them was loose and broken. There was no true ulceration. Scattered petechial haemorrhages were found over the trunk. There was large sub-conjunctival haemorrhage at the lateral canthus of the right eye. The whole area of skin in this region was ecchymotic. A recent subcutaneous haemorrhage had occurred over right zygma. Nose - right side blocked by blood clot and possibly ? membrane. There was similar collection in posterior nasopharynx. There were several small haemorrhagic sores about finger nails. No haemorrhage into gums.

The whole area of the anal cleft, perineum and inferior part of scrotum were denuded of epidermis. It was firm, with dark haemorrhagic base. There was no deep ulceration.

No external signs of injury. Deep post-mortem lividity and rigor mortis present.

Internal Examination:- Skull not opened.

Chest: - (1) Left Lung. Pleural cavity free of fluid. Section of lung showed bronchi full of blood-stained frothy fluid. ? Scar at left apex. Bronchial glands slightly enlarged and haemorrhagic. There was a large infarct in left lower lobe involving about 2/3 of it. Several smaller ones were scattered over the upper surface.

Rightlung. Passive congestion with multiple small infarcts in lwer and middle lobes. No free fluid in pleural cavity.

(2) Heart. Incfease in amount of pericardial fluid

which was dark yellow. Amount about 50 c.c. Heart muscle pale, and coronary vessels and branches very prominent. There was medium sized infarct at apex of left ventricle.
No petechiae seen on pericardial surface.
Endocardium. Small petechial haemorrhage into wall of right ventricle posterior to Inferior Vena cava. Scattered haemorrhagic areas in trabeculae of inter-ventricular wall and in papillary muscles both sides but more numerous on left side. These had appearance of being of recent occurence. Mitral valve showed few old nodular swellings on free border of cusps. Some degree of athecoma about the left coronary orifice. Aorta appeared normal.

Abdominal Cavity:- Some subcutaneous fat. Musculature good. Scattered petechial haemorrhagic [illegible] over [illegible] parietal peritoneum. The Omentum was speckled with numerous subserous haemorrhages of varying sizes.

(1) Stomach: - Nil abnormal seen.

(2) Small Intestine:- Scattered subserous Haemorrhages. The fat and mesentery close to the intestine was almost continuously haemorrhagic in character. The mucous surface was normal in appearance. The haemorrhages did not involve the muscle coat as far as could be seen.

(3) Large Intestine:- Caecum normal. The haemorrhage along mesenteric border and into fat deposits continued. The gut was normal colour but there were scattered petechiae on mucus surface getting more numerous as the distal end was approached.

(4) Liver:- Normal size. Icteric tinge and suggested early fatty degeneration. Gall Bladder - Normal texture. Filled with very dark inspissated bile, no stones.

(5) Pancreas: - Normal in size and appearance.

(6) Spleen:- Slightly enlarged and engorged. Septicaemic type.

(7) Kidneys:- Slightly pale - nothing abnormal seen.

(8) Adrenals:- Normal size. No haemorrhagic areas. Cortex pale and medulla was of pale grey colour.

(9) Bladder:- Contained about 60 cc. dark brown urine with flakes of ? albumen present. Very slight

injection of walls.

Skin. Section through sore on left leg showed a dark haemorrhagic base just below epidermis. Tissue below this was normal in appearance and there was no evidence of inflammation.

CAUSE OF DEATH:-

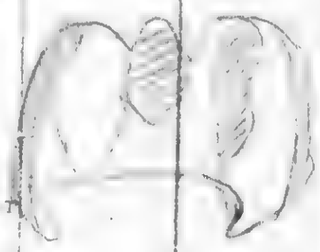
1. Septicaemia, probably due to infection fromskin.
2. Myocardial failure due to multiple haemorrhagic petechiae in muscle.

W.D. Gunn

Surgeon Lieut. Commander R.N.

CASE No.

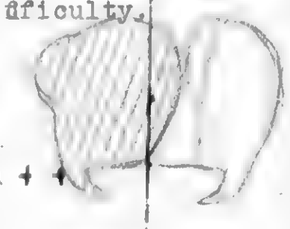
No.	2-5		NAME OF DIAGNOSING DOCTOR		[illegible] Jackson
UNIT	Royal Scot	NATIONALITY		RANK / NAME	Private Gibson
NAME OF DISEASE	Diphtheria	DATE ADMITTED	18/7/42	DATE DISCHARGED	Died 19/7/42 6.15. P.M.

DATE	TREATMENT	REMARK
18/7/42	Acutely dysphagic, dyspnoeic and dysphonic. unable to give history beyond:- 5 days ago onset of sore throat. G.P.O. Very distressed unable to lie flat, sores at oral margins covered with membrane. Left nares, oozing serum at margins and interior covered with grey membrane. T. 101. P. 128. "Bull neck", & cervical tenderness.  Fauces grade II & some obstruction of pharynx. Unable to see naso-pharynx Chest: Lung fields clear. Heart: Enlarged III 1½ | 1½ L.N.T. Pulse volume. poor & regular rhythm 128/.  Soft blowing systolic apical murmur. Some evidence of Rt. failure, distended veins pulp liver. &c. Abdomen. Reflexes present. Rectum. Extensive secondarily infected. Times moist and untreated. Legs - Tinea of feet and ankles, Septic spot ? toe Rt. foot. Blood: A pure number of Staphylococci with the morphological appearance and staining reactions of C. hæmolyticum diphtheriæ. Urine: Albumen + +	
19/7	Very poor night, takes fewer copiously sweetened drinks without difficulty. Respirations very embarrassed pulse 160, poor volume. It was decided to do tracheotomy at 10.30 a.m. carried out without difficulty and with considerable relief to patient. Patient still unsatisfactory at times, extremities cyanosed, face, sullen, and blotchy, chest irregular movements. Rales could be attended to all over chest at times. Serous discharge from both nostrils with extension of membrane beyond mucous surface, salivation & from mouth. Laryngeal spray used. Condition deteriorated as afternoon progresses. Patient died at 6.15 p.m.	

CASE NO.

No.	282		NAME OF DIAGNOSING DOCTOR		C... Jackson
UNIT	Royal Navy	NATIONALITY	British	RANK NAME	Coder BEVAN
NAME OF DISEASE	Faucial Diphtheria	DATE ADMITTED	18/7/42	DATE DISCHARGED	Died 19/7/42. 11.15. p.m.

DATE	TREATMENT	REMARK
18/7/42	3 days ago. Onset of sore throat headache and pains in back, speech and swallowing became difficult. Neck became very swollen. C.O.A. Very dysphonic, lies flat c difficulty. gross bilateral swg of neck with acute inflammation of skin over it. Tongue furred but moist. Opens mouth c difficulty. Fauces and soft palate covered c membrance.on right side extends beyond mid line to include uvula. Salivation + + Pulse. 110 pm. regular but poor volume. Heart. not enlarged. Lung filds clear. Abdomen. Reflexes present. Legs. K.J. not elecited. Urine Very alk, no alb. detected. Smear: Many diphtheroids occurring in clumps seen among a variegated flora.	
18/7	5.45, After restless night, with acute dysphagia, suddenly coughed and became obstructed, - blue cyanosis + + Sister cleaned airway by pulling tongue and jaw forward sufficient to make inspiration just possible. Emergency tracheotomy performed, in sittying posture much venous congestion made proceeding difficult and led to the aspiration of a certain amount of blood. With Durham's tube in perfect, airway not obtained at once owing to inability to cough up laryngeal & tracheal obstructions. Had mild rigour immediately after operation. recovered most comfortable in Fowler's position. Severe basal congestion of lungs & bubbling rales, which improved after about two hours of quieter respirations. Then more restful. Swallowing very small quantities of fluid with great difficulty. Intravenous glucose saline commenced at 12 noon. Blood, cross compatibility with convalescent patient found satisfactory. 7.30 pm. Sudden twist of neck while being moved off bed pan caused tube to come out.--acute respiratory distress. Tube reinserted - settled & calmer after 20 mins. but very exhausted by dyspnoea & distress. Heart rate up 130pm. Became more settled later, mouth tube but full of courage. Further 20 cc of glucose morphia 1/6. Atropine 1/180 gr. 8.20 another attack of acute dyspnoea. Found after some difficulty to be due to a left lateral deviation of tracheotomy aperture and sudden movement of neck caused short Durham's tube to come out. This tube was replaced with another larger pattern after which respirations settled down.	



91200

lung fields both very congested. Colour slightly cyanosed still a grey pallor.
Had two slight rigours, which associated with physical exertion of dyspnoea left patient very exhausted. Pulse rate barely countable at wrist, of poor volume. Temp. rising.
At. 11.15. pm. Although respirations were quiet and unembarrassed, the heart gradually failed. Terminal temperature was 109°

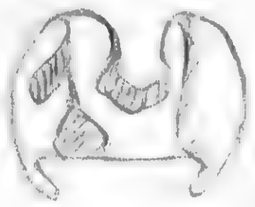
Death. 11.15. p.m.

(1) Pharyngeal Diphtheria

(2. Myocardial Failure

CASE NO.

NO.	251		NAME OF DIAGNOSING DOCTOR		J.A. Jackson
UNIT	Royal Corps Signals	NATIONALITY	British	RANK NAME	Signalman Lees, John
NAME OF DISEASE	Faucial Diphtheria	DATE ADMITTED	4/7/42	DATE DISCHARGED	20/7/42 (Died)

DATE	TREATMENT	REMARK
4/7	c/o sorethroat and difficulty in swallowing. H.P.C. 3days ago; onset of symptoms associated a headache pains in back and bones. feverish. C.O.A. Pulse 86. Temp 98° no respiratory distress dysphagia. Tongue furred. Pharynx inflammed and membrane formation in post fold, small non confluent. Slight adenitis c tenderness. Chest v. Heart. slight bradycardia. Legs. - Reflexes, sluggish. Scar in lin from drainage of peri renal abscess.  Urine - No albumen.	
5/7	Pain right. c/o soreness in throat. some increase in pharyngeal envolvement. Brady cardia remarked upon 60	
6/7	Pharynx . slight improvement although, he still complains of dysphagia. No evidence of membrances separating. Smear 4/7/42. Diphtheroid organisms seen in mixed flora.	
8/7	Faucial infection under control, membrance cleaner no c/c.	
9/7	Extension of membrance to post'ior pillar and pharynx. General condition not so good. 	
10/7	No further involvement this a.m. mentally brighter no gross obstruction to laryngeal or esophagical passages - Taste poorly.	
11/7	Oedema of neck slightly increased. still depressed - condition of fauces unchanged. Urine: - Trace of albumen.	
12/7	Big blacked tonsil and extension onto post pillar  much le oer Deglutation ++ Feels better with less dysphagia. Chest v. Heart les bradycardia. p.m. Pulse good volume but rate now more comparable c temp. Very dysphonic this evening c increase of swg in neck. Rt. tonsil covered by necrotic slough c membrane or secondary infection	

Inject Phonzin 5 ccs. - Continued c Sulphathiazole tablets two at 10 pm. and 4 am. 8.am. 12 noon. Rather anxious about himself.

13/7. Satisfactory response to chemotherapy.
Discomfort in neck less. better colour and pulse good volume.
Epistaxis left nose.
p.m. improved tonight.

14/7. Dysphagia & dysphonia still acute, excessive blood stained discharged from mouth & nose . Very toxic and ill.
Chest. BrBi over right mid zone c increased vocal fremitus -- transmitted sounds from pharynx.
Smear:- From Rt. tonsillai membranes Predominent organism has mosphology and staining characteristic of Corynebackim diphtheria.

15/7 Had more restful night after having Mist 3xvs. . Fauces, foul necrotic; haemorrhagic mess, which is being expectorated, uvula and nasopharynx involved. Chest; P.S. unchanged. Heart Over-accentuation of isv Sound at initial and pulmonary bases. Colour isnrather pallid, complaining less but is still very worried about himself.

16/7 Expectorating much blood stained mucus. Right nares obstructed c haemorrhagic membrane. Cardiac condition i.s.q.

17/7 Generally a little improved, throat clearing gradually myocardium . no noise.

18/7 Appears a little weaker a.m. not taking fluids well. Condition of fauces in much cleaner. -- Force fluids per.os. on all occasions.
Urine: show light cloud of albumen.

19/7 Very satisfactory - appetite improving.

20/7 Depressed this a.m. Radial pulse volume poor. Aortic Sounds irregular in time and power.
Has been unusually alert all day and enjoyed his usual tea. This evening he complains that breathing is difficult at times, Clinically there's appreciable deterrioration in his cardiac condition, peripheral Cyanosis, irregular and pressureless pulse, tender liver margins and distended cervical veins.

At 8.50 p.m. was talking to sister, when he collapsed and died of myocardial failure. Respirations of sighing- gasping type persisted for five minutes after "cardial death"

Cause of death

Myocarditis with heart failure on 20th day of onset. Faucial Diphtheria

time 8.50 pm.

July 20th 1942.

C.A. Jackson .

		Name of Attending Dr	Rodrigues.A.M.		
Unit	R.Engineers.	Nationality	Scot.	Rank and Name	Spr. Grant.Wilders
	Enteritis.	Date admitted	20.7.42	Date discharged	23.7.42

	Treatment	Remarks
20/7	Mag.Sulph. 2 drms.6-hourly,on admission. Temp.104F Pulse,96. Aspirin 5 grs. and Morphia ¼gr.H.I.given at night.	
21/7	Temp.103F in the morning.Stools with mucus and blood,practically every20 minutes. Mag.Sulph.continued.Patient slightly delirious. Morphia ¼gr.given at night by injection.	
22/7	Condition unchanged.Kaolin given. No improvement in patient_stools still frequent-Temp.102F Morphia ¼gr. H.I.	
23/7	Patient semi-conscious and pulse deteriorated-weak and rapid-110 Inj.Coramine lc.c. given at 8 a.m.Bismuth Salicyl.5 grs. given 4-Hr. No change ,patient becoming moribund; Died 1.10 p.m.	

Lieut.H.K.V.D.C.

Augusto Rodrigues

02200

	279				GUNN
	Midd/Sx.		Br.		Pte. SIMMONDS. Bertie
	1. Acute Bronchitis 2. Scabies 3. Cardiac Failure		18.7.42.		Died! 23.7.42.

Reported sick. 7 wee s ago c̄ septic bullae on hands & legs. 5 days ago caught cold & has been coughing up much sputum. Has fair degree of dyspnoea, has some pain in lower chest. The pain is not continuous, only present when coughs. Sputum is tenacious & difficult to cough up. It is thick and greenish. No history of haemoptysis or streaking. Sweats freely but doesn't know if he has had any fever. Never short of breath prior to onset of illness. Has not felt well for some time. (This may be due to conditions of living rather than disease).

Had chest trouble 1 year ago. Was in Bowen Rd. M.H. Diagnosis bronchitis. Sputum & X- ray negative then.
No known contact c̄ T.B.

O.E. Flushed- breathless & worried in appearance.
Tongue furred, smooth & complains of it being swollen.
Throat N.A.D.

Heart: Pule rapid, poor quality. No evidence of edema.
A.C.D. Normal in size. Heat sounds clear - poor quality.

Respiratory System Resp. movements shallow and accessory muscles being used. Sl. less movement on right side. P.M. Sl. impaired over right upper zone. Right base dull. B.S. broncho-vesicular except at right base - absent. V.F. some & over right upper & mid zones - absent at right base. Scattered rales & rhonchi over both sides, but more marked on left.

Abdomen - N.A.D.

Skin - Advanced scabies over hands wrist, lower abdomen & thighs.

19/7 Very dopey, dyapnoeic & cough troublesome, finds it v. difficult to raise sputum. Slept in snatches. Is not taking food or fluids well.

Sputum: Pustular - thick - odorless
No tubercle Bacilli seen.

20/7 V.Sl. improvement. V.Difficult c̄ food & fluids cough severe. T.N. but sweats alot & P.R. is rapid. Scabies clear.

21/7 Slept very poorly but states h feels more rested. Cough increased much more fluid - Signs in chest more general & Sl. increase in fluid at the right base.

22/7 Much better today, taking food & fluids quite well in small amounts. Cough severe during the night but rested. No change P.R. v. rapid.

23/7 Sl. less dyspnoea today. Color fair. Fair night. Cough less . Looks more haggard & wasted.
W.B.C. 14.800 - predominate polys.
1500 - collapsed - V.cyanosed pulse thready. Lapsed into unconsciousness & C-S. breathing. DIED 17.20

W.D.Gunn

No. 2 Hospital 24/7/42.

POST MORTEM - Pte. Simmonds. B. Middlesex.

External Examination: Thin man with healed and partially healed scabetic rash over lower abdomen, hands, things and feet. Small sores over sacrum. P.M. lividity and rigor mortis present.

Internal Examination: Skull not examined.

Chest: Emphysema of substernal cellular tissue. No free fluid in pleural cavities.

Left Lung - Soft adhesions between base and diaphragm and recent inter-lobar adhesions. All bronchi dripped pus - creamy and thick. Most marked from lower lobes. Dilatation of lower lobe bronchioles with irregularity of walls. Upper love bronchioles not dilated. Mediastinal and intra lobar gland injected and swollen.
Right Lung - Upper and middle lobe showed similar condition. Lower lobe firm cut easily. Cut surface congested, red with haemorrhagic purulent exudate- This area late red hepatisation. Glands enlarged, and inflammatory. Much creamy bronchial secretion.

Heart: No increase in pericardial fluid. Heart small. Normal externally in in systole. Large antemortem clot in right auricle. Valves normal.

Abdomen:-
Stomach and Intestines: Normal appearance.
Spleen - Normal size.
Liver - Advanced nut-meg liver

Remainder not examined due to shortage of time.

Cause of Death: (1) Acute septic Bronchitis and Pneumonia secondary to bronchi-ectasis.
(2) Myocardial failure.

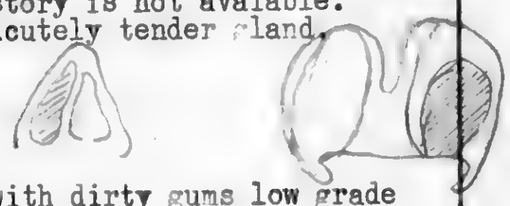
W.D. Gunn

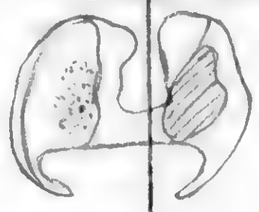
Surgeon Lieut. Comdr. R.N.

No.	284			Name of Diagnosing Doctor	C.A.Jackson
Unit	Royal Navy	Nationality	British	Rank Name	Supply Asst. Davies
Name of Disease	Diphtheria	Date Admitted	18/7/42	Date Discharged	Died 12.10 P.M. 23/7/42.

Date	Treatment	Remark
18/7/42	Onset two days ago Sore throaat.. dysphagia ++ sore of neck and headache, felt very ill & drowsy. O.E. so dysphonic that detailed history is not avaiable. thick bilateral cervical swg with acutely tender gland. Left tonsil and right nostril covered c membrance. T. 100 Pulse 100 pmin. Tongue dirty, moist, stainedteeth with dirty gums low grade pyorrhoea. Dyspnoea Airway appears adequate left oral margin and small area right lower lip have membraneous patch. Chest. Heart Tachycardia Abdomen. Reflexes ++ Scrotum. Area of infected scabies Leg. A.I. and V. I not elicited. Urine. No albumen present. Smear: A very mixed flora in which diplococes and bacilli are present in numbers, several diphtheroids seen.	
19.8	Very anxious about him self. and in evening was fearful that in going to sleep breathing would become more difficult. Examination reveals that although membrane is very extensive covering nares and nasopharynx, airway is comparatively good. Oedema of neck is increasing.	
20/8	Slept well from midnight. no respiratory distress. dysphonia more apparent, also cervical oedem. Cardiac rate still high but is satisfactory in other respects. Urine: No Albumen present. Increased cervical swg. p.m. extending onto face, right side worst. There appears to be a membrane on post aspect of this tonsil otherwise faucial condition unchanged.	
21/8	Oedema of face now extended to involve right eye. Pharynx still very swollen. Airway satisfactory. On course of Sulpha thiazole., Dull and listless but appears less toxic than he was. P.M. Retained 760. well with exception of 2.p.m dose - complete course and finish. There has been an appreciable improvement in temperature, but pulse rate has remained on high level 98/mt. is of poor volume and pressure. Pharynx is more oedematous, airway satisfactory but taking fluids difficult at times and promotes coughing. There are no cocomitent signs of cardiac failure but condition of myocardium remains very poor. Keep specimen of urine.	

Increased oedema





E2203

22/7. Very fair night, constantly expectorating, Pharynx more oedematous but airway clear. Swg of face now occludes rt eye. Small septic spots on face and membrane on right lower lip.

Cardiac condition remains poor, but is of good colour and has no respiratory distress.
Ulcer of heal dressed c hot faks - cleaner.
Urine: - Solid c albumen!

23/7. Slept poor during night, constantly expectorating blood stained mucus. Complains of being very hot, but is actually cold and clammy. peripheral circulatory failure at 4.a.m. Given strychnine gr 1/50 with some temporary response. Generalised cyanosis and oedema of head & neck. Many septic spots about the face -- Is in dying condition 4.45. although still conscious.
orphia given.
Died . 12.10 p.m.

Toxic myocardial failure.
due to Faucial Diphtheria

C.A. Jackson

No. 2 Hospital 24/7/42.

POST MORTEM - S/A Davies, K.V. R.Navy.

External Examination: Well nourished young male with very bull neck and oedema of right side of face. Crusting about nares - right. Numerous petechiae over the face, these had ruptured through epidermis and were slightly crusted. Small haemorrhage into conjunctiva lateral canthus right eye.
Mouth and gums clear of haemorrhage.
Few scattered petechial haemorrhages over trunk.
Small haemorrhage into skin with broken surface in the dependant part of the scrotum. Had haemorrhagic sores on both heels, right about 6 cm., left about 2 cm. in diameter.
No evidence of wounds or injury. P.M. Lividity and rigor mortis present.

Internal Examination: Skull not opened.

A. Pharynx and Larynx. Pharynx and fauces generally coverd by haemorrhagic membrane. The tissues were swollen and edematous with large collections of albuminous fluid. The tonsils, peritonsillor tissue, etc, were dark red and firm. The membrane extended as far as the larynx.

B. Chest:- Lungs. Left Lung - Scatterd petechiae over the visceral pleura only. No free fluid. The lung had a pink congested appearance, was normal in consistency and full of air.
Right Lung - No free fluid. Firm consistency, but cut easily, very congested except for small area at the apex. There were scattered areass which were more deeply congested and firmer, suggesting hepatisation.
Heart - Slight increase in pericardial fluid. No petechiae on pericardial surfaces. Heart pale externally - cut muscle beefy in appearance. In systole. Endocardial surface fairly normal, few small sub-endocardial petechiae in right ventricle in papillary muscles.
Valves normal in appearance.

C.Abdomen: Small amount of extra peritoneal fat.

Omentum - Normal appearance.
Liver - Toxic type. Gall bladder normal.
Kidneys - Both congested, no petechiae.
Spleen - Very small, toxic in appearance.
Adrenals - Normal in appearance.
Pancreas - Normal.
Bladder - Normal, small amount (5 c.c.) residual urine.

PostMortem - S/A. Davies, D.V. R.Navy (Cont.)

Stomach - Normal.

A few scattered haemorrhages along the mesenteric border of the gut - mostly about ileo-caecal region. A large sub-endotheleal haemorrhage in the base of the mesentery near the junction of the splenic vein. Gut appeared normal. Lymph glands normal in appearance.

Cause of Death: (1) Haemorrhagic Diphtheria .
(2) Toxic Myocarditis.

W.D. Guhn
Surgeon Lieut. Comdr. R.N.

No.	2570			NAME OF DIAGNOSING DOCTOR	Partar Singh Lem I.M.D.
UNIT	H.K.S.R.A.	NATIONALITY	Indian	RANK / NAME	Gunner • Mushi Mohd
NAME OF DISEASE	Anaemia Pernicious	DATE ADMITTED	28.6.42	DATE DISCHARGED	Died 24.7.42.

DATE	TREATMENT		REMARK
28.6.42.	Complains of giddiness duration 3 weeks duration 1 ½ Month Fever Lungs & heart normal Spleen not palpable Tongue coated Anaemic Mist Saline ½ Hot Water Bottle Stools and urine for examination Negative Blood for M.P. Negative.		
30.6.42.	Mist feri et Ammon citrus Spleen++ Liver + Stools no ova or cyt Seen Blood no M.P. seen.		
17.42	Stool negative ga ova J.E.H.	6.7.42	Milk bottle ½
		7.7.42	"
6.7.42	c/o of sever weakness Running of temperature daily. Milk ½ bottle daily.	8.7.42	"
		9.7.42	" 1 ½
		10.7.42	"
7.7.42.	Blood for M.P. Negative.	11.7.42	"
		12.7.42	"
8.7.42.	Blood picture: R.B.C 1,300,000 W.B.C. 3 2,800 H.B 45% C.I. 1.7 Diff. P.L.M.E.	13.7.42	" 1
		14.7.42 to 20.7.42	"
	Polychrionate & Punstats Basophiolia Mint Soda Salicylas ½ B.D.	21.7.42 to 24.7.42.	Milk bottle 1½
17.7.42.	Fever still continued (1) Mist Feri et Ammon citas ½ B.D. (2) Mist Crepest Stim. ½ B.D.		
23.7.42.	Signs of heart failure. Tri digititis & Pot citrus mist ½ B.D.		
24.7.42.	Condition very grave in the morning. Coramine 1 cc. S.C. given No improvement. The patient expired at 6.10 P.M. 24.7.42.		

CASE 434

No.	18518		NAME OF DIAGNOSING DOCTOR		Jem. P.S. Sangha I.M.D.
UNIT	2/14 P. R.	NATIONALITY	Indian	RANK NAME	Sep. Age:22 Jumman Khan
NAME OF DISEASE	Acute Intestinal Amoebiasis	DATE ADMITTED	28.6.42.	DATE DISCHARGED	Died 24-7-42 1 pm.

DATE	TREATMENT	REMARK
28.6.42	Rice Water AD. lib. Mist. Saline Routine Doses.	
30.6.42	Stop Saline. Emetin Gr. 1. c.c. daily.	
7.7.42	Total 8 grains of emetine given. Mist Bismuth ℥ii.	
10.7.42	Lusil Tablets 4 B.D.	
11.7.42	Lusil Tab. 6 in the morning	
13.7.42	Mist Bismuth ℥i T.D.S.	
19.7.42	Hypertonic saline 2 pints (I.U.) pot. permanganate Tab.2 every 15 minutes until the stool changes its colour.	
20.7.42	Mist Bismuth ℥i 7h. Kaoline - ℥ii at H.S. Pot. Permanganate Tab.2 every 4 hourly.	
21.7.42.	Bismuth ℥ii T.D.S. Enema Simplex ½ 1½ pints every 4 hourly Morphine - gr ¼ (Hypo) every 6 hourly.	
22.7.42	Rpt. all except morphia	
23.7.42	Rpt. all daily	
24.7.42.	The Patient exp ired at 1 p.m.	DIED

N.B. Pasary
Jem. I.M.D.

Chutan Dev.
Jem. I. M. D.
Comdg. 3 P.O.W. Hospital.

CASE

No.	301		NAME OF DIAGNOSING DOCTOR		Gunn
UNIT	R.A. 12th C. Regt.	NATIONALITY	Br.	RANK NAME	Gnr. Brown, William
NAME OF DISEASE	Bacillary Dysentery	DATE ADMITTED	24.7.42	DATE DISCHARGED	Died 25/7/42.

DATE	TREATMENT	REMARK
	Reported sick 6 weeks ago, c temperature, diarrhoea and passing blood & mucus. Bowels open v. freq. 20 times. Pain severe & continuous No headache. Vomiting following inoculation? Patient has periods of irrationality - unable to get more history. O.E. V.weak & shocked - Mentally v. slow. Tongue- furred moist. Skin cold & Clammy. Pulse v. rapid & weak. Abdomen - soft - v. tender. Stool. almost pure blood & some mucus. 23.00 Patient collapsed temporarily. -- still very cold & unconscious. Breath deep. 0345. Patient died. W.D. Gunn	

Gnr. Brown
One of those
I moved to Isolation
as mentioned by
Capt Rodrigues

Rodrigues

No.	290			NAME OF DIAGNOSING DOCTOR	C.W.Jackson
UNIT	Royal Corps of Signals	Nationality	British	RANK & NAME	Signaller Herbert ROGERS
NATURE OF DISEASE	Faucial Diphtheria	DATE ADMITTED	24/7/42	DATE OF DEATH	Died 1.15 a.m. 25/7/42.

DATE	TREATMENT	REMARK
24/7/42	.Two days ago Sudden onset of sore throat with headache, dysphagia, and swelling of neck, did not feel particularly unwell except for local discomfort. Reported sick and was admitted to hospital. C.Q.A. A flushed healthy looking man with acute dysphonia deep croaking voice, bilateral cervical swelling, right side greater than left. Noticeable exophthalmosis of right eye, both being protuberant beyond normal. Temp. 101. Pulse 100 p min. forceful and regular. Local condition Tongue heavily furred moist, foetor oris offensive, lips & buccal mucus membrane healthy. Both tonsils grossly enlarged comprissing an uv la in the mid line Oedematous Nasal airway satisfactory. A grey "Ghost-like membrane extends from tonsils onto soft palate - Salivation ++ Tender cervical adenitis. Heart. Bounding thrustful cardiac in pulse Rate tending to settle after rest in bed. Lungs Normal Abdomen Reflexes present. Urine None obtained Smear: Report to come.	
25/7/42	At 110 am this morning when rolling over onto right side to spit into bowl, was suddenly seized with acute laryngeal obstruction, and before tracheotomy could be performed the patient collapsed and died. 1.15 a.m. Cause of death Asphyxia and Cardiac failure from Laryngeal obstruction due to diphtheria C.W. Jackson.	

No.	299		Name of Diagnosing Doctor		Gunn
Unit	12 C.R., R.A.	Authority	Br.	Rank Name	Gnr. Keeble, George
Nature of Disease	B. Dysentery	Date Admitted	24/7/42	Date Discharged	Died 25/7/42.

Date	Treatment	Remark
	Reported sick 6 weeks ago. No temperature. Passing blood & mucus. No Headache. Some vomiting. Has had abd. pain. but is now easier. Blood & mucus still being passed. No headache, but has been unable to sleep for some time. Malaria - Dec. 1941 Dysentery: No. No other complaints. O.E. Tongue furred & dry. Abd. marked tenderness over whole abd.	
25/7	99° 120 ++ Very dry mouth. Very dozey but is more awake. V. severe abd. pain. 1400 Condition deteriorating. Morphia grs 1/6 ē atropine grs 1/180. Patient died at 1515 WDG.	

Gnr Keeble
One of the cases mentioned St Theresa's Hospital Typhoid Paratyphoid

CASE NO.

No.	236		NAME OF DIAGNOSING DOCTOR		Gunn
UNIT	12 C.R. R.A.	NATIONALITY	British	RANK NAME	THOMAS, Douglas
NAME OF DISEASE	(1) B. Dysentery (2) Toxic Delirium	DATE ADMITTED	24/7/42	DATE [illegible]	Died 26.7.42.

DATE	TREATMENT	REMARK
	Delirious on admission - No history obtainable.	
	O.E. Tongue v. dry. Abd. v. tender	
25/7	Condition unchanged. Still delirious and has been vomiting. green bile colored fluid. V. dehydrated. Pulse thready & poor.	
	2100 Condition fair, had several lucid intervals & has taken fluids, etc. quite well.	
	0255. Patient died.	
	W.D. Gunn.	
	Cause of Death (1) B. Dysentery (2) Toxic Myocarditis.	

Jno. Thomas
Rodriguez
one of the bearers
Cape Town

CASE NO.

No.	287			NAME OF MEDICAL OFFICER	Gunn
UNIT	H.K.V.D.C.	ARM OR SERVICE	Br.	RANK AND NAME	Lieut. GUTERRES Joaquim
NAME OF DISEASE	B. Dysentery	DATE ADMITTED	20.7.42.	DATE DISCHARGED	Died 26.7.42.

Date	TREATMENT	Temp
	Reported sick 2 days ago c chills & fever. Aching in back etc.	
	Now has fever headache etc. B.O. XXV Loose watery stool c with blood.	
	Tongue - furred. T 103. P.110. Abdomen - Tenderness over caecum & descending colon. Chest - N.A.D.	
21/7	T.102 130. B.O. XV Looks & feels much better- less pain. Tongue cleaner & less furred.	
22/7	100 - 112. Pulse v. much better. B.O. frequently & incontinent several times. Sleeping.	
23/7	T.100 - 124. B.O.+ + Irrational during night & not very stable now. Some abd. pain - tongue moist.	
24/7	T.101. P.120. Bo. 10. V. restless & was incontinent. Now has hiccoughs sl. Pulse fair volume. Is partly Mental.	
25/7	T.98 P.114 B.O. ++. Delirious during night & incontinent. Pulse fair. Occ. hiccoughing. Abdo. v. distended.	
26/7	T.N. P.120 Incontinent. Blood & mucus still . Pulse good - condition fair.	
	Died 2100	
	W.D.Gunn	

CASE NO. 406

No.	15431/5522		NAME OF DIAGNOSING DOCTOR	Kartar Singh Jemadar IMD	
UNIT	5/7 R. R.	NATIONALITY	Indian	RANK NAME	Sepoy Lakhan Singh	Age- 24 Years
NAME OF DISEASE	I. Anaemia Pernicious II. Stomatitis	DATE ADMITTED	18.6.42	DATE DISCHARGED	DIED 31.7.42. 2.a.m.

DATE	TREATMENT		REMARK
18.6.42.	Patient c/o dyspepsia and loss of appetite . Duration 15 days. Anaemia +++ Temp.100 Spleen - palpable liver - palpable Blood for M.P. Negative Re - Mist .A.P.C.	23.6.42.	Milk bottle ½
R.B.C.- 1,113,00 W.B.C.- 3,000	19.6.42 Stools for ova Negative - Urine Nil abnormal Mist Ferri et Ammonia citras ℥ss B.D. Cod liver oil Mxx B.D. & gargles.	to 27.6.42 4.7.42 to 9.7.42	" " "
H.B.-55% C.I.- r-54 L-44 E-1 E-1 No abnormal all day.	30.6.42 Still getting fever. Mist Quinine ℥ss B.D.	10.7.42	bottle 1½
	3.7.42 No abatment of fever. Blood negative 4 times 30.6.42. Stop Quinine. Mist Feri et ammonia citras ℥ss B.D. Cod liver oil Mxx B.D.	11.7.42 12.7.42 13.7.42	bottle 2½ bottle 3 bottle 1½
	10.7.42 Developed gum boil. Incissed. Gargles	14.7.42 to 16.7.42	bottle 1 "
	12.7.42 Constipated. Soap & water enema		
	14.7.42 Stools for ova Negative. Urine for general examination Nill abnormal.	17.7.42 to 23.7.42	" ½ "
	20.7.42 Fever has subsided.	24.7.42 to 30.7.42	bottle 1 "
	23.7.42 Again rise of temperature.		
	25.7.42. Constipated. Soap & water enema. No improvement in general conditions.		
	27.7.42. Pulse feeble, Heart sounds are feeble. Hypertonic saline 1½ pints given.		
	28.7.42 General condition not improving. Face & eye lids swollen. not to move from the bed.		
	29.7.42. Slight difficult in speech. Anxious look. Pulse quick & thready. Strychnine 1/60 gr. given S.E. Smear from mouth: neg. from C. diphtheria.		
	30. 7.42. Condition worse.		
	31.7.42 Expired at 2.a.m. Kartar Singh Jem. I.M.D. DIED 2.a.m. 31.7.42. Chutan Dev. Jemadar I.M.D. Comdg. 3rd F.W.H.		

Case No.	----	Name of diagnosing Dr.		Capt. A.H.R.Coombes, R.A.M.C.	
Unit	R.A.F.	Nationality	British	Rank and Name	Cpl. HUNT L.R.
Name of Disease	DIPHTHERIA (Faucial)	Date admitted	28.7.42.	Date of discharge	Died 4.55.a.m. 4.8.42.

Date	Treatment	Remarks
28.7.42.	Gargles 2 hourly with Carbolic 1/200. Aspirin gr. 10 b.d.	Tonsillitis.
29.7.42.	Gargles continued. Aspirin gr. 10 b.d.	Diphtheria.
30.7.42.	Gargles and Aspirin continued as above.	Membrane Spreading rapidly.
31.7.42.	Gargles and Aspirin continued.	Condition considerably worse.
1.8.42.	Pot. Permang. gargles hourly - 1 in 5000. Aspirin gr. 10 b.d.	
2.8.42.	Pot. Permang. gargles hourly - 1 in 5000. Dagenan tabs. 8. Aspirin gr. 10 b.d.	Cardiac condition developed
3.8.42.	Pot. Permang irrigations 1 in 5000 every ½ hr. M & B 693 tabs. 6. Aspirin gr. 10. Coramine 8.a.m. 1.7c.c. and at 5-30.p.m.	Moribund.
4.8.42	Heart Failure. - Death.	Died 4.55.a.m.

CASE NO.

No.	14961 13978			Name of Diagnosing Doctor	Jem. P.S. Sangha I.M.D.	
Unit	5/7 R. R.	Nationality	Indian	Rank	Sep.	Age:27yr Ser:4 yr
				Name	Feroze Khan	
Name of Disease	Dysentery	Date Admitted	30.6.42.	Date Discharged	Died $4\frac{8}{42}$ at 8 p.m.	

Date	Treatment	Remarks
30.6.42	Rice water Mist Saline Routine doses.	
10.7.42	Stop Saline Given a course of Ol. chenopod 10.a.m. Mist saline ℈i 1.p.m.	
11.7.42	Mist. iron tonic ℈i BDS.	
19.7.42	Lusil 4 ttab. BO. Quinine mixture ℈i Tds. Thimine - ½ c.c. 8 such (injection).	
20.7.42	Rpt all except lucil Tab. Quinine bisulph - gr x. (Im.)	
21.7.42	Rpt all.	
22.7.42	Soda mint Tablets two at 9 p.m. Rpt all daily except quinine injection.	
24.7.42	Quinine Bihydrochlore - gr x (I.m.) Mist Quinine ℈i TDS.	
25.7.42	Omit Quinine injection. Soda mint tablets two at 8 pm. Enema simplex - 1½ pints.	
29.7.42	Enema simplex - 1½ pint Mist Quinine ℈i TDS. Hypertonic saline - 1½ pint (I.V.) given	Condition of patient is serious
30.7.42	Mist M.P.C. - ℈i T.D.S. Enema Hot c Eusol lotion - 1 pint daily.	
3.8.42	Rpt. all.	Condition dangerous
4.8.42	Hypertonic saline - 1 pint. The patient expired at 8 p.m.	

N.B. Pasary.
Jem. I.M.D.

Chutan Dev.
Commanding 3rd Prisoners of war Hospital.

CASE NO. age 23 years.

No.	5085		Name of Diagnosing Doctor		Captain B.I.Evans I.M.S.
Unit	20th Baty. 12th C.R., R.A.	Nationality	Indian	Rank	Gunner
				Name	Noor Khan
Name of Disease	Pulmonary Tuberculosis	Date Admitted	27.5.42.	Date Discharged	Died at 8 am. on 5.8.42.

Date	Treatment	Remarks
27.5.42	Patient complains of fever with rigors, general weakness and flatulance dyspepsia. Duration : 2 months. Lungs . spleen not palpable. Condition on Rt. apex + Stool for ova. No ova seen. No.9 tabs 2 at 8.p.m. Sputum for TB. TB +++ Mist saline ℥i early next morning. Wasting marked. ---- Blood for M.P. Negative.	
28.5.42	Mist Cal Lact. ℥i TDS. Aqua Menthpip ℥i B.D.P.C. } Daily.	
16.6.42	Omit all. Mist saline - ℥i (Stat)	
17.6.42	Oil china podium - m 20 Carbon Tetrachlore - m 40 Castor oil - ℥i } Followed by Mist saline - ℥i three hours later.	
18.6.42	Mist Cal lact. - ℥i TDS Mist Iron tonic - ℥i BDPC. } Daily	
25.6.42	Omit all. Mist Saline - ℥i (Stat)	
26.6.42	Chlorform - m 45 Castor Oil - ℥10 } Followed by mist saline - ℥i three hours later.	
27.6.42	Mist Cal lact. ℥i TDS.) Mist Iron tonic- ℥i BDPC) daily	
4.7.42	Omit all Mist Bismuth - ℥i TDS. Aquamenthpip- ℥i BDPC. } daily	
15.7.42	Omit all Mist Kaoline - ℥i TDS. Kaoline powder 3 ++ B.D. Soda min Tab - 1 BDPC. } Daily	
25.7.42	Rpt all. Hot enema c Lusol lotion - 1 pint.	
1.8.42	Rpt all.	
5.8.42	The Patient expired at 8 a.m.	

N.B. Pasary
Jem. I.M.D.

Chetan Dev.
Jemadar I.M.D.
Commanding 3fd Prisoners of War Hospital.

CASE NO. 547

No.	7782 - 182		Name of Diagnosing Doctor		Kartar Singh Jemadar I.M.D.
Unit	H.K.S.M.A.	Nationality	Indian	Rank	Sepoy
				Name	Gulam Mohd (22 Yrs.)
Name of Disease	Fracture Base of the Skull	Date Admitted	6.8.42.	Date Discharged	Died 8.8.42.

Date	Treatment	Remarks
6.8.42	Had a fall from a house, sitting in a window. Felt dizziness and fell down. Bleeding from the nose and ear. c.w. scalp stitched. Dressed. The patient received in a comatose condition with difficulty in breathing. Ear to be lightly pluged with sterilized cotton as oftenas necessary. urine drawn with catheter.	
7.8.42.	Temp. 100° F. Resp. 32. No signs of pneumonia. condition looks very serious. Urine drawn out with catheter. 15 oz. free from albumen. Breathing stentorous.	
8.8.42.	Patient expired at 3 A.M.	
	Chetan Dev. Jemader I.M.D. Commanding 3rd Prisoners of War Hospital	
6.8.42. Temp: 98.4. Pulse:80		

Case No.		Name of diagnosing Dr	CAPT. AVR. COOMBES. RAMC.
Unit	Royal Marines.	Nationality British.	Rank and Name Reginald GUPPY. Sergeant.
Name of disease		Date admitted	Date of discharge Died 8.50 p.m. 8/8/1942.

Date	Treatment	Remarks
1/8/42	Saline irrigations to nose.	Diarrhoea. Nasal discharge.
2/8/42	Gargles hourly with Carbolic 1 in 200. Fluid diet with milk (powder),	Developed sore throat with membrane of left tonsil.
3/8/42	Gargles 1 in 200 Carbolic hourly. Fluids.	Membrane spreading to other tonsil.
4/8/42	Gargles continued.	Soft palate and Uvula involved.
5/8/42	Gargles with Pot. Permang. 1 in 1,000.	
6/8/42	Irrigations to throat 1 in 200 Carbolic.	General Condition very poor. Tachycardia.
7/8/42	Coramine 1.7 c.c. 7 p.m. Irrigations with Carbolic Gargle 1 in 200.	Very weak. Gradually became worse.
8/8/42	Coramine 5 p.m. 1.7 c.c.	Died 8.50 p.m.

CASE NO.

No.	5091		Name of Diagnosing Doctor		Captain B.I. Evans I.M.S.
Unit	No.3rd M.Baty. H.K.S.R.A.	Nationality	Indian	Rank	Gunner
				Name	Shah Jahan
Name of Disease	Ulcerative Colitis	Date Admitted	19.5.42.	Date Discharged	Died 6/8/42 at 7.45 p.m.

Date	Treatment	Remarks
	Age: 22 yrs. Service 4 yrs.	
19.5.42	Mist Saline ℈i every hour for 8 doses & gargles.	
22.5.42	Emetine 1 gr. S.C. Total 7ngrs given	
	Stop emetine -	
29.5.42	Normal saline 1 Pt. given S.C.	
	Mist D.P.C. ℈i Stat	
30.5.42	Mist soda salicyles ℈ij TDS.	
2.6.42	Stools still contain traces of blood & Mucus	
	No. in cyst seen. exudate Bacillary.	
	Mist saline ℈i Stat.	
	Mist saline ℈i every hour for 6 doses.	
8.6.42	Stop saline	
	Give mist. bismuth ℈i BD.S	
10.6.42	Mist tonic ℈i B.D.P.C.	
	Mist Alvaline ℈i BD.S.	
20.6.42	Cont. Above.	
25.6.42	Tab. M.&B. 2 only.	
10.7.42	Lusil tablets - 4 B.D.	
11.7.42	Lusil tablets - 4 B.D.	
12.7.42	Lusil tabletsv- 4 only.	
13.7.42	Mist Bismuth ℈i T.D.S. daily	
19.7.42	Mist Iron tonic ℈i BD.PC.	
21.7.42	Enema simplex - 1 pint	
22.7.42	Mist Bismuth ℈i TDS.	
25.7.42	Lusil tablets - 4 given then 4 every 4 hours. 16 Tab.	
3.8.42	Hypertonic saline - 2 pints. I.V.Given. Special mixture -4 doses at night given.	
4.8.42	Kaoline ℈ij 4 such every 3 hourly.	
8.8.42.	Camphor in oil - 1.c.c. (Hypo) Given.	
	The patient expired at 7.45 p.m.	

N.B. Pasary , Jem. I.M.D.

Chetan Dev.
Jemadar I.M.D.

Commanding 3rd Prisoners of War Hospital.

CASE NO. 403

No.	3701		Name of Diagnosing Doctor		Jemadar I.M.D.
Unit	17th A.A. Baty. 5.A.A. Regt. R.A.	Nationality	Indian	Rank	Gunner
				Name	Janga Singh
Name of Disease	Entero Colitis	Date Admitted	11.6.42.	Date Discharged	Died on 9.8.42. at 2.a.m.

Date	Treatment	Remarks
11.6.42	Weight: 17.6.42-145½ lbs 2.8.42 -130 lbs. c/o Swelling feet, ankle and legs and weakness. Pyorrhoea ++, Gums swollen and spongy. Oedema over feet, ankel and legs. Rx:-(1) Thimine ½ s.c. 3 day followed 1/4 cc. S.C. (2) Mist Pot. citras ¼ B.D. Pill No.9 and mist Saline ½ 3 gargls.	
20.6.42	To dentist. Treatment given.	21.6.42 Milk bottle ½ 22 "
27.6.42	Treatment of pyorrhoea completed.	24.7.42 Milk bottle 1/4 25.7.42 Milk bottle ½
30.6.42	Oedema much less.	to 3.8.42 "
6.1.42.	Thiamine Stop. Urine & stools - no ova.	4.8.42 Milk bottle 1
12.7.42	Stools No ova.	
23/7/42	c/o light cough. Re- mist sepectstine ½ B.D.	
26/7/42	Stomatitis - Caustic touch to the ulcer.	
28/7/42	Sever stomatitis. Ulcer on tongue & buccal. m.m. Re gargles every two hours. Blood for M.P. Negative.	
31/7/42	Fever less. Ferri et Ammon citras ½ B.D.	
4.8.42	Again fever Blood for M.P. Blood Picture: Polychromoplahia & Norhoblast (R.B.C.-800,000 (W.B.C.-8,000 (H.D = 30% (C.I. = 1.9 (P = 62 (L = 32 (M = 6	
5.8.42	Mist Quinine ½ TDS. Quinine Bihydrochlore grs. 10 I.M. Stat. Cold sponging given	Condition serious, stools passing involuntarily Patient semi-conscious.
7.8.42	Rpt. all. Kaoline Pulv - ½ twice daily.	
8.8.42	Cold sponging given twice. Mist Quinine ½ TDS. Pituitrine ½ c.c. (Hypo) Given at 12 midnight.	
9.8.42	The patient expired at 2 A.M. N.B. Pasary, Jem. IMD. Chetan Dev. Jemader I.M.D. Comdg. 3rd Prisoners of War Hosp.	

CASE NO. 411

No.	P. No. 8707		Name of Diagnosing Doctor		N.B. Pasary Jem. I.M.D.	
Unit	No.2 Coy I.H.C.	Nationality	Indian	Rank	Naik	Age- 43 Years Service 20 Yrs.
				Name	Chhatan Lama	
Name of Disease	Pulmonary Tuberculosis	Date Admitted	18.6.42.	Date Discharged	Died 9.8.42 at 9 A.M.	

Date	Treatment	Remarks
18.6.42	Patient complains of dyspnoea, frequent stools, and griping pains on abdomen. Duration: 3 weeks. Patches of consolidation over both apries. Rigidity over abdomen Emaciation + Oedema of left foot & lower leg + Stools for ova & cysts. For observation. Sputum for T.B. Acid Fast Bacilli +++ Mist Saline ℥i every hour for 6 doses. Temp. 98.	
20.6.42.	Mist Cal Lact. ℥i T.D.S. daily.	
5.7.42.	Omit the mist. Mist Saline ℥i(stat) then ℥i every hour 6 doses.	
6.7.42	Mist saline - ℥i 4 times	
8.7.42	Mist Bismuth ℥i TD.S. Soda Bicarb - 3 p Pot Citras - 3 p Tr.Digitalis-M10 Aqua - AD ℥i TDS. } Daily	
15.7.42	Rpt All. Soda Mint Tab. 2 BD.	
30.7.42	Kaoline Powder ℥ii TDS. Ft Mist.	
4.8.42	Special Mixture ℥i T.D.S. Mist Bismuth ℥i B.D.	
9.8.42	The patient expired at 9 A.M. N.B. Pasary Jem.I.M.D. Chetan Dev Jemadar I.M.D., Commanding 3rd Prisoners of War Hospital.	

CASE NO. 1

No.	No. 156		Name of Diagnosing Doctor		Surg/Lt.Commander Gunn, R.N.
Unit	R.A. 5th A.A.	Nationality	British	Rank	Sergeant
				Name	Salisbury, Thomas
Name of Disease	Chronic Enteritis Faucial Diphtheria	Date Admitted	25.5.42.	Date Discharged	DIED 9.8.42. 12.30 A.M.

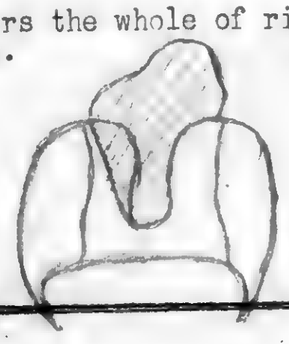
Date	Treatment		Remarks
25/5/42	Dysentery in December - well for a short while but has had diarrhoea since February. No blood present now - no slime - motions v. loose - & occ. porridgy. No vomiting. Headache + . Has "Black-outs" several times. Tenesmus only. Swam harbor & swallowed water there. Has generalised initating rash over trunk & areas under arms & about pubis. Foreskin is difficult to retract especially when erected. 1 Mist 3 $\overline{xv}$'s H.S.	B.	Minced Full No Rice.
26/5	B.O. iii. Since admission, none during the night. Initation much relieved. Slept well. (1) Scabies routine	B.	Minced Full No Rice.
27/5	B.O.v. V. painful still itching ++ (1) Stool to Lab.	B.	Fluids Only
27/5	B.O. iv. Mist 3 $\overline{xv}$'s H.S. Stool - porridgy & frothy. some mucus Mixed. Pus +++ & organisms. No. R.B.C.		Fluids Only No Bread
28/5	Much better. B.O.T. less pain diarrhoea unchanged. (1) Mist 8 $\overline{xv}$'s H.S. (2) Bath only. Clear of scabies. (3) tinct.Opii & Billadonnu T.D.S.	B. B.	Fluids
1/6	Consid. pain during night, when B.O. but slept fairly. Motion unchanged.	S/B. 2. Mashed Potato 3. Small port. Ground rice. No.Vegetable.	1. Minced Meat Double portion.
2/6.	Less pain & motions which are frequent.	B.	+ Fluids
3/6.	No Pain - B.O.ii. No change in consistency.	B.	--
4/6.	Impr. M.T.	B.	--
10/6.	B.O.II during night. Less pain - mostly wind. Blood reduced-but mucus +	B.	--
12/6.	uch improved less pain. Stools V.L. mucus.	B.	(Minced (No Veg. (& Fluids
13/6.	Improved.	Up 1 hr. am & pm.	
15/6.	B.O. ii . less pain. no Bom.		Minced.
16/6.	Improved	Up. 2 Hrs. B.D.	FULL
17/6.	B.O. I. No pain & firmer N.T.	2 Hrs B.D.	FULL

EX200

CASE NO.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	Salisbury, Thomas
Name of Disease		Date Admitted		Date Discharged	

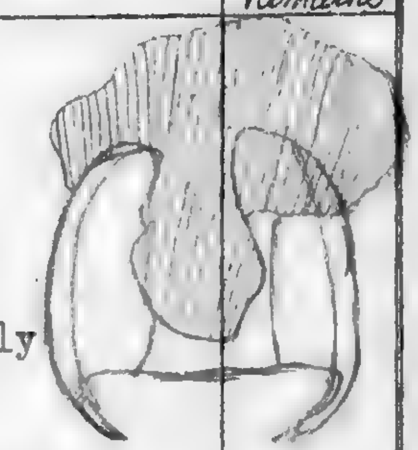
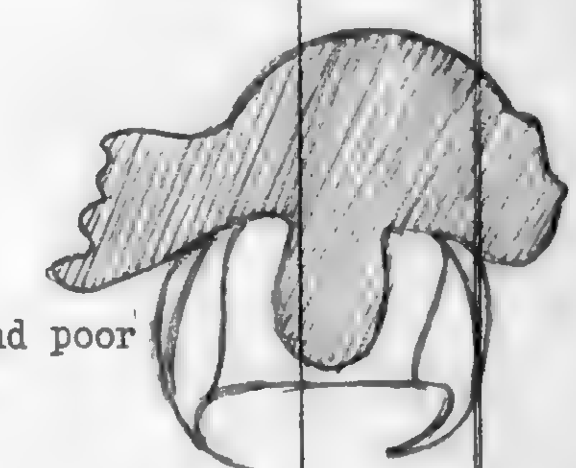
Date	Treatment	Remarks
18/6	B.O. iv. c̄ pain. N.T.	2hrs. B.D. Minced
23/6	B.O. iv some pain etc.	4hrs. B.D. Mince
25/6	Nauseated c̄ Trianon. B.O. i. V.L. pain.	
6/7	B.O. Imp. No Blood or mucus present. porridgy.	
8/7	B.O. v. c̄ some pain. Has some clear mucus c̄ little pus at some times.	
11/7	Bowels open 12 times. Mostly small - watery mucoid motions. c̄ some pain. Stools are more normal.	
13/7	Had severe pain c̄ 16 motions last night - Still has numerous small mucoid motions. v.l. blood. Appetite has diminished lately.	
15/7	B.O. ix. vomited 2 cc. c̄ pain. Motions are unchanged in character - still has mucus. C.W.C. show no improvement.	
16/7	B.O. vii. but feels better -- ? less quantity.	
20/7	No Change in condition. Still has some pain & blood & mucus.	
23/7	Severe pain & marked diarrhoea during the night.	
24/7	Pain less - had restless night. B.O. less times. Still v. tender.	
25/7	B;O. 7. - v. restless night. Looks poorly.	
28/7.	Stools semi-solid - pain on defaecation only. Some mucus.	
29/7	T.100. Pain less. B.O. freq. during night but partially formed. general condition fair.	
30/7	98 - 76 - B.O. 4. Much better. less pain feels quite well & slept better.	
31/7	97^6 - 84 - B.O.6. Some pain - still has mucus. but generally tends to feel rather better, though he is thin & pale.	
2/8	B.O. 5. Still has mucus & trace of blood in stool. Sl. more solid. Less pain.	
3/8	97^8 - 68 - 4. B.O. no change. V.L. pain. V. thin.	
5/8	Throat V. sore - oedematous c̄ whitish membrane over wholearea and cervical adenitis right side.	
6/8	V.L. change in throat - a membrane covers the whole of right tonsil & uvula. Some difficulty in swallowing.	
	T. 100. P.108. B.O.2 Transferred to Diphtheria Ward	



Tonsils not involved membrane separating right soft palate & uvula.

CASE NO.

No.		Name of Diagnosing Doctor			
Unit		Nationality		Rank	
				Name	Salisbury, Thomas
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
7/8	Considerable extension of membrane, which covers the greater parter of the soft palate is grey black in colour. Salivation ++ and increased cervical adenitis. Satisfactory airway and no dyspnoea. Smear. 6/8/42. Small clumps of organisms morphologically consistent with Corynebacterism diphtheria Sccu. Bowel open + 2. B.& M c trace of blown fluid. 11 p.m. extreme tachycardia 144 p min regular rhythm, mental condition very good and full of fight. Given 4000 units. Antitoxin 1M. (sera was too tubulescent to give I.V.)	
8/8.	General extension of membrane over soft and posterior hard palate. Airway perfectly good, no increase in dysphagia. B.O. c̄ greenish shine result x 4 hocte. Cardiac condition very poor c̄ extreme tachycardia and poor pressure. Had sleepless night. 10.45 a.m. 6000 Units. intravenously.	
8 P.M.	Condition has deteriorated throughout day. TThere is now and impending peripheral failure. Airway adequate .. Morphia give at 5.25 to relieve mental anxiety & secure rest.	
9/8/42	Death - 12.30 a.m. (1) Facial Diphtheria (2) Chronic Enteritis	

Case No.		Name of diagnosing Dr	CAPT. A.A.K. COOMBES RAMC		
Units	8th.COAST REGT. R.A.	Nationality	British.	Rank and Name	Bdr. CASEY, JOHN, STEPHEN.
Name of Disease	DIPHTHERIA.	Date admitted	7/8/42.	Date discharged	11/8/42. 11.30. a.m.

Date	Treatment	Remarks
7/8/42.	Gargles with Pot. Permang. 1 in 5000. 2 Hourly.	Admitted with Tonsillitis.
8/8/42.	Gargles with Carbolic. 1 in 100. (hot). 2 Hourly.	Membrane suspicious of Diphtheria developed.
9/8/42.	Gargles continued. Fluids only.	Membrane spreading over fauces and uvula.
10/8/42.	Irrigations with Carbolic 1 in 100 hourly. Fluids.	General condition very poor. Some Dyspnoea.
11/8/42.	Coramine 1.7.c.c. Tracheotomy. Death from Asphyxia due to Laryngeal Diphtheria.	Condition worse. Asphyxia. Death 11.30 a.m.

Case No.		Name of deceased	Rodrigues A.M.		
Unit	Royal Scots.	Nationality	Scot.	Rank and Name	L/Cpl. DOUGLAS, Robert.
Name of Disease	Enteritis.	Date Admitted	8.8.42	Date discharged	11.8.42

Date	Treatment	Remarks
8/8.	Admitted with abdominal pains and diarrhoea with raised temperature - 100 F. Ol.Ricini 8 gms. given at once. Mag. Sulph. 8 gms. given in the afternoon.	Diet-fluids only.
9/8.	Patient weak - 18 stools during the night. Trianon tablets 2 t.d.s. given. Condition improved slightly but some nausea felt.	Temp. 99 F. Pulse 100.
10/8.	Vomited twice during the night - had six stools. Trianon tablets continued - 2 tabs. twice only. Patient considerably weaker later in the day, but stools decreased in frequency. Appeared quiet at night but in a dehydrated condition.	Temp. 98.6 F. Pulse 98.
11/8.	12.15 a.m. patient noticed to be sleeping. Had vomited a few times earlier on. 12.40 a.m. respiration increased and distressed. On examination chest found to be clear - respiration rate 30. Temp (under axilla) 100 F. Pulse could not be felt at the wrist. Fingers and toes cyanosed. 2 c.c. Coramine given hypodermically, but no improvement noticed. Patient sinking rapidly. Died at 1.20 a.m.	

Signed,

A.M. Rodrigues, M.B., B.S.,
Lieutenant, H. K. V. D. C.

Case No.		Name of diagnosing Dr	Captain A.H.R. Coombes, R.A.M.C.		
Unit	Hong Kong Volunteer Defence Corps.	Nationality	British.	Rank and Name	Gunner BAKER, Lawrence.
Name of Disease	Diphtheria.	Date admitted	8.8.42	Date of discharge	2.55 p.m. 12.8.42

Date	Treatment	Remarks
8.8.42	Admitted with Tonsillitis. Gargles with Carbolic 1 in 200 hot. Aspirin grs 10 nocte.	? Diphtheria.
9.8.42	Gargles continued. Fluid diet. Aspirin grs 10 b.d.	Extensive membrane present.
10.8.42	Gargles as above. Irrigations with 1 in 200 Carbolic. Chloral Hydrate grs 20 9 p.m.	Membrane spreading.
11.8.42	Gargles and Irrigations of throat continued. 1.7 c.c. Coramine 7 p.m.	Condition worse. Dyspnoea.
12.8.42.	Gargles and Irrigations continued. Coramine 1.7 c.c. 9 a.m. Tracheotomy in vain.	Very poor condition. Died 2.55 p.m.

Baker Dift.

Coombes

Case No.		Name of designing Dy.	Captain A.H.R. Coombes, R.A.M.C.		
Unit	8th Coast Regt., R.A.	Nationality	British.	Rank and Name	Gunner GRINTON, Eric.
Name of illness	Diphtheria.	Date admitted	3.8.42	Date of discharge	Died 12.8.42 4.20 p.m.

Date	Treatment	Remarks
3.8.42	Gargles with Carbolic 1 in 200. Aspirin grs 10 nocte.	Tonsillitis.
5.8.42	Gargles continued. Aspirin grs 5 b.d.	? Diphtheria.
6.8.42) 7.8.42)	Repeat 5.8.42.	Membrane definite and spreading.
8.8.42	Gargles continued. Chloral Hydrate grs 15 7 p.m.	Condition becoming slowly worse.
9.8.42	Gargles. Aspirin grs 15 8 p.m.	
10.8.42	Gargles continued. Chloral Hydrate grs 20 10 p.m. Coramine 1.7 c.c.	
11.8.42	Chloral Hydrate grs 20 8 p.m. & Coramine 1.7 c.c.	Dyspnoea marked.
12.8.42	Coramine 1.7 c.c. 9 a.m. Coramine 1.7 c.c. 2 p.m. Chloral grs 20 3 p.m.	Died 4.20 p.m.

Case No.		Name of Informing Relative			
Unit	8th Coast Regt., R.A.	Nationality	British.	Rank and Name	SKINNER, Ernest. QMS.
Name of Disease	Diphtheria.	Date admitted	8/8/42	Date of discharge	Died 11.40 p.m. 13/8/42

Date	Treatment	Remarks
8/8/42	Admitted with Tonsillitis. Gargles 1 in 200 Carbolic. (hot) 2 hourly. Aspirin grs 10 nocte.	? Diphtheria
9/8/42	Gargles continued. Aspirin grs 15 nocte.	Definite diphtheritic appearance of fauces. Membrane extensive.
10/8/42	Gargles continued. Aspirin grs 10 nocte.	
11/8/42	Gargles continued. Chloral Hydrate grs 15 nocte.	Condition worse. Membrane spreading.
12/8/42	Gargles continued.	Membrane all over soft and hard palate.
13/8/42	Irrigations with Carbolic 1 in 200 hourly. Coramine 1 c.c. 12 noon.	Cardiac failure. Died 11.40 p.m.

Case No.		Name & designation	CAPT. ANK COOMBES. RAMC.
Unit	Hong Kong Volunteer Defence Corps.	Nationality	British.
Name of Disease	Diphtheria.	Date admitted	6.8.42
Rank in Army			
Date of death or discharge			14.8.42 10.15 p.m.

Date	Treatment	Remarks
6.8.42	Admitted with sore throat and multiple septic sores. Gargles with Carbolic gargle 1 in 200. Eusol dressings to sores. Trianon 8 tabs. (2, 4 hourly).	? Diphtheria.
7.8.42	Repeat gargles and dressings. Trianon 8.	Definite tracheal membrane.
8.8.42	Gargles. Dressings as above,	
9.8.42	Gargles and dressings repeated.	Membrane very thick but airway good.
10.8.42	Gargles and dressings repeated.	
11.8.42	Gargles and dressings.	No improvement.
12.8.42	Gargles and dressings.	Disease progressing.
13.8.42	Irrigation to throat.	Condition very much worse.
14.8.42	Coramine 1.7 c.c. 9.00 a.m. Tracheotomy 5.00 p.m. Strychnine 6.00 p.m.	Cardiac Failure. DIED 10.15 p.m.

Harrington
Dip. Cmdr

		Name of Admitting Dr.		Rodrigues A.M.	
Unit	R.A.O.C.	Nationality	British.	Rank and Name	Pte. PATERSON, John.
Name of Disease	Enteritis and Myocarditis.	Date Admitted	22.7.42.	Date of discharge	15.8.42.

Date	Treatment	Remarks
22/7/42.	Admitted with Diarrhoea, abdominal pain and fever. T.101.F. Oleum Ricini given, 8 gms stat.	12 stools for the day.
23/25th.	Mag Sulph.4 gms t.d.s. Stools still continued as frequently. but pain decreased. Temp. 100.F. in evenings.	
26/1.8.	Kaolin given 8 gms. t.d.s. Stools still Diarrhoeic. Large Blisters appeared on face and a few on shoulders. Diagnosis of ~~buttocks~~ - Impetigo - confirmed by Major Officer, R.A.M.C. (Skin Specialist). Dressings with Eusol and Kaolin.	
2/8/42.	Trianon Tablets 6 a day - 8 stools.	
3/8/42.	" " 4 a day - 2 stools. Very much improved.	Temperature normal.
4/8/42.	Kaolin t.d.s. Although Diarrhoea was much improved bullae still appear as quickly as old ones dry up. Patient very emaciated. Tongue raw and interior of mouth denuded in parts of layer of mucous membranes.	
5/8/42.	Injection of Thiamine and Nicamide given. Condition unchanged.	
7/8/42.	Another Nicamide injection in form of Coramine given hypodermically. Ascorbic Acid tabletsgiven 2 daily - continued for 5 days. Morphia at night gr.¼.	Powdered milk given.
9/8/42.	Temperature 101.F. Pulse 110. Weakness extreme. Trianon Tablets given by mouth. (4 for the day).	
11/8/42.	Vomiting and inability to eat food. Temp 99.F. Pulse 100. Heart action irregular but later on regular and fast.	Diet - Milk powder.
13/8/42.	Coramine given morning and night. - 1 c.c. each time. Morphine ¼ gr. tablet at night.	Diet - Fresh milk and sardine cakes but not retained.
14/8/42.	10 a.m. Coramine - Vomited 5 times throughout day. Temp.101.F. Pulse 110. 8 p.m. slight heatt attack lasting 20 mins. Coramine 1 c.c. given H.I. 10 p.m. Morphia ¼ gr. by mouth.	Temp.98.6.F. Pulse 110.
15/8/42.	Delirious 2. a.m. subsiding with Coma - Coramine given 2-30. a.m. Died 3 a.m.	

A.M. Rodrigues, M.B. B.S.
Lieut. H.K.V.D.C.

No.		Name & designation of Pt.	CAPT. DRK COOMBES RNMC		
Unit	Royal Navy.	Nationality	British.	Rank and Name	DEAN. Reginald, A.B. Ernest.
Name of disease	Diphtheria	Date admitted	10.8.42.	Date discharged	15.8.42. Died 9-15 a.m.

Date	Treatment	Remarks
10.8.42.	Admitted with Tonsillitis. Gargles 1 in 200 Carbolic. 5 times a day. Aspirin gr.5. nocte.	? Diphtheria
11 /8/42.	Repeat - Gargles. " Aspirin nocte.	Definite membrane in throat.
12.8.42.	" - Gargles. Chloral gr.30. 9. p.m.	Extention of Membrane marked.
13.8.42.	" - Gargles.	Thick membrane spreading all over throat.
14.8.42.	Gargles repeated. Milk Diet only. 1½ pints.	Condition very poor.
15.8.42.	Coramine 3.a.m. Died 9-15 a.m.	Collapsed.

Dear Dick R.M. Coombes

Case No.		Name of Surg. Officer	CAPT. A.H.R. COOMBES RAMC
Unit	Royal Navy.	Nationality	British.
Name of Disease	Chronic Enteritis. Diphtheria.	Date Admitted	14.8.42
Rank and Name	ANDERSON, John. Sgm.
Date of Discharge	16.8.42. Died 9,55 a.m.

Date	Treatment	Remarks
14.8.42	Gargles with 1 in 200 Carbolic. Milk pints 1½ daily.	Admitted with Diphtheria from Main Wards where in with Chronic Enteritis since 6.8.42. Very weak. condition. Diarrhoea marked. Very poor pulse.
15.8.42	Gargles continued. Milk 1½ pints daily.	Rapidly becoming worse. Throat only moderately affected.
16.8.42	Milk and fluids only. Gargles. Strychnine grs 1/30 act. repeated once.	Died 9.55 a.m. after collapse.

NOTE.

Previous Dysentery once in North Point. P.O.W. Camp.
" " " " Shamshuipo P.O.W. Camp.
Chronic Diarrhoea for 6 months.

No.		Name of deg. Surn & Ch	Capt. AHR COOMBES RAMC		
Unit	Royal Army Pay Corps.	Nationality	British.	Rank and Name	BACKHURST, Keith. Pte.
Name of disease		Date admitted	14/8/42.	Date of discharge	16.8.42 Died 7.15 p.m.

Date	Treatment	Remark
14.8.42	Morphine gr ½ by mouth.	Admitted with severe pain over right forehead and maxilla. Had a good night's sleep and felt much better in morning. Temperature up in evening to 99.4°. Swelling over right eye and right temporal region increasing during day. Very ill. Cheyne Stoke's breathing. Died 7.15 p.m.
15.8.42	Aspirin grs 20 b.d.	
16.8.42	Hot fomentations. Trianon 12 tabs. (4 t.i.d.)	

Case No.		Name of deceased	Capt. A.H.K. COOMBES RAMC
Unit	Hong Kong Volunteer Defence Corps.	Nationality	British.
Rank and Name	ROBERTS, Stanley. Pte.		
Name of disease	Diphtheria.	Date Admitted	11.8.42
Date of death	Died 16.8.42 11.40 p.m.		

Date	Treatment	Remarks
11.8.42	Admitted with Tonsillitis. Gargles Carbolic 1 in 200. Aspirin grs 20 nocte.	? Diphtheria. Previous Diphtheria in 1937, treated in Hong Kong with anti-toxin.
12.8.42	Gargles. Fluid diet and milk. Aspirin grs 10 nocte.	Definite membrane present on both tonsils.
13.8.42	Gargles. Milk.	
14.8.42	Gargles. Milk.	Condition increasingly worse.
15.8.42	Gargles continued. Chloral grs. 30.	Very much worse.
16.8.42	Gargles continued. Chloral 20 grs. Strychnine 1/30 gr. Tracheotomy at 11.00 pm.	Cardiac Failure. DIED 11.40 p.m.

CASE NO		NAME OF DIAGNOSING DOCTOR	CAPT. AHR COOMBES RAMC.		
UNIT	12 C. R.A.	NATIONALITY	British.	NAME AND RANK	MORLEY, Frederick. B.S.M.
NAME OF DISEASE	Malnutrition. Chronic Enteritis.	DATE ADMITTED	6/8/42.	DATE DISCHARGED	17/8/42. died 3.00 am.

DATE	TREATMENT	REMARKS
6/8/42	Chronic Diarrhoea. Mist Bismuth gr 15 b.d. Codein Phos. grammes .03 nocte.	Admitted from St. Teresa's.
7/8/42	Mist. Ferri et Ammon. Cit. gr 20 b.d. Codein.	Very thin man with Cardiac weakness.
8/8/42.	Rep. Mist.Ferri. Tar paste to hand. Bismuth gr 15 nocte.	Not improving.
9/8/42	Rep. above.	Analuria marked.
10/8/42	Rep. above.	Sores of left hand very troublesome.
12/8/42	Rep. above. Thiamin 10 mgms. (1 c.c.)	Became much weaker.
15/8/42	Gargles and repeat above medicines.	Developed Tonsillitis (mild).
16/8/42	Gargles continued and medicines.	
17/8/42.		Died from Cardiac failure during night.

NOTE. Previous Beri Beri, Malnutrition and Chronic Diarrhoea for 4 months.

CASE NO. 464

No.	11052		Name of Diagnosing Doctor		N.B.Passary Jemadar, I.M.D.
Unit	5/7th R.R.	Nationality	Indian	Rank	L/Nk.
				Name	UDAN SINGH
Name of Disease	Broncho Pneumonia	Date Admitted	13.7.42	Date Discharged	Died at 9.15 a.m. on 17.8.42.

Date	Treatment	Remarks
13.7.42	Complaints: Frequency of stool consisting of blood & mucus and sore mouth. No. of stools in 24 hours 12. Examination: Extremely anaemic. Liver & spleen enlarged. Blood for M.P. negative. Oedema of feet ++ Rest in bed. Stool picture that of:- Mouth washes freqently Bacillary Dysentery Mist saline ½ every hour for 6 doses. Microscopically.	
16.7.42	Motile E.H. seen in stools microspopically. Rest in bed. Mist saline ½ every morining. Emetine Hydrochlore 2/3 grain subcutaneously daily for 6 days.	
30.7.42	Mist iron tonic ½ T.D.S. W.C. Total RBCs = 700,000) Poly 33 % 31.7.42. WBCs = 1800) Lympho = 67 % Milk - ½ bottle daily Haemoglobin = 25%) colour index = 1.8. 2.8.42. Picture of blood that of Pernicious Anaemia with Milk - 2 bottles daily Polychromasia, Punctate Basophilia etc.	
3.8.42.	Temperature irregularly continued. Blood for M.P. Negative. Swelling of face and feet + Signs of heart failure ++ Liver & spleen enlarged +	
4.8.42	Stools liquid contain blood & mucus. Reaction alkaline. Microscopically picture of "Bacillary Dysentery + Mist saline ½ every hour for 6 doses. Rice water ad lib. Enema of hot Eusol (½ in 1 Pt).	
9.8.42	Omit all. Lusil Tablet - 4 stat followed every 4 hours by 4 tablets three timess.	
10.8.42	No change. Lusil tablets - 4 tabs: B.D.	
11.8.42	Condition rather hopeless. Patient refuses to take nourishment. Thiamine ½ cc. S.C.	
12.8.42	Temp: last evening 99.4 F but has touched normal [illegible]. Stools free from blood & mucus. Oedema of face and feet much less. Thiamine 1/4 cc daily continued.	
13.8.42.	Prostration increasing. Signs of mental instability have often been manifested. Frequently urine passed involuntarily in clothes. Signs of heart failure ++. Bowels moved twice. Stools free from blood & mucus. Mist Kaolin ½ B.d. Hot enema with Eusol Sponging - thrice daily.	
14.8.42	No improvement. Mist Ferri Tonic ½ B.D. P.C.	
15.8.42	Patches of consolidation in lungs with bronchial breathing increased vocal resonance and fremitus have appeared. Patient comatose and has passed urine & stools involuntarily.	

CASE NO.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	UDAN SINGH
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
	(2)	
15.8.42	Temp 99 F. Pulse rate 120 p.m. Resp. 44. Triamon Ampoule 10 cc. I.M. Liquid Adrenalin ½ c.c. B.D. Mist stimulant expectorant 4 hourly (with tinct. Digitalis) Sugar water & Rice water ad lib.	
16.8.42	General condition hopeless. Sinking pronounced. Nourishment forced. Treatment continued.	
17.8.42	Patient expired at 09.15 hours after protracted illnesses having suffered recently from Enteric group of fevers for 19.4.42 to 3.6.42 , then mixed bacillary and II Amaetric Dysenteries III Pneumonia Lobular. N.B. Pasary Jemader I.M.D. Chetan Dev. Jemadar I.M.D. Dai Ni Bunken Sho.	

CASE NO.		NAME OF DIAGNOSING DOCTOR	Capt. HR Coombes-Rose		
UNIT	H.K.V.D.C.	NATIONALITY	British.	NAME AND RANK	LONGFIELD, Stuart. Private.
NATURE OF DISEASE	Diphtheria. Beri Beri.	DATE ADMITTED	17/8/42.	DATE DISCHARGED	18/8/42. Died 1.20 pm.

DATE	TREATMENT	REMARKS
17/8/42	Gargles Carbolic 1 in 200. Coramine 11.30 pm. 1.7 cc.	Very wasted. Previous Beri Beri (still under treatment. Diarrhoea. Diphtheria.
18/8/42.	Coramine 1.7 c.c. 9.45 a.m.	"Heart Attack".
	Coramine 1.7 c.c. 11.00 a.m.	"Heart Attack".
	Coramine 1.7 c.c. Strychnine 1/30 gr. Morphine gr ¼ and Atropine gr 1/60.	"Heart Attack". DIED 1.20 p.m.
	Previous illness - Beri Beri over three months.	

CASE NO. 907

19493/531				KARTAR SINGH Jem. I.M.D.	age 19
2/14th PR		INDIAN	RANK AND NAME	SEPOY HABIB KHAN	
DISEASE Pneumonia Lobar R.T. Lung	DATE ADMITTED 8.8.41		DATE DISCHARGED	DIED. 19.8.42 4.20	

DATE

8.8.42 c/o, 1. Pain on the chest more marked on the right side
2. Fever and Cough
3) Weakness

Examination:- General health very poor patient is anaemic.
Spleen: Palpable.
Heart. Normal
Lungs. A few rales on the right side and occasional Rhonchi on the both sides.
Temp. 99.4°F. Pulse 79. Resp. 24
Reflexes Normal. No rigidity of the neck etc.
Blood for M.P. Negative.
Stools for ova. Negative.
Urine for general examination. Nil abnormal.

9.8.42. Temp. Normal. Feeling little better.
11.8.42 Temp. 100. Blood for M.P. Neg.
12.8.42 Temp 99.2 Blood for M.P Neg.
13.8.42 C/o of fever cough. Lungs. Still a few rales.
14.8.42 Fever 103.4°F. Pain in the right side of the chest. Signs of Pneumonia lobar in right side upper lobe. Placed on Lucil Tab.
15.8.42 Fever 102.8. General condition little better
16.8.42 Fever has come down.
17.8.42 Again little rise of temperature. Chest still shows rales
Patient does not take food.
18.8.42 Vomiting. General condition Very Serious. Normal Saline 2 pints S.C. One pint. Hypertonic I.V. Hot tea, milk.
19.8.42. Condition of the patient is very Serious. Pulse imperceptible. unconscious has marked a pneumonia with rhonchi all over. at 4 P.M. ... DIED at 4.20 P.M. of Heart failure.

Kartar Singh
Jem. I.M.D

Jemadar I.M.D.,
Commanding Dai Ni Bunken Sho..

處方錄
PRESCRIPTION

入院月日
DATE ADMITTED
8·8·42.

部隊號 UNIT	2/14 H. P.R.
官軍級氏名 NAME AND RANK	HABIB KHAN SEPOY.

責任者氏名
OFFICER IN CHARGE
KARTAR SINGH. JEM.I.M.D.

月日 DATE	處方 PRESCRIPTION	療養食 DIET
8.8.42	1, mist Salinae gr. 4 3 mg 6 hrs 2, mist sedat Stim gr. BD 3, Menthol in habitat 4, oil to Eucalyptus & the chest	
14.8.42	Lasil Tab. 6, 4, 4, 4, 6	Milk bath 14.8.42 —2— & 19.8.42 —a—
15.8.42	—" — —" —	
16.8.42	—" — —" —	
17.8.42	—" — 4, 2, 2, 4.	
18.8.42	—" — —" —	
19.8.42	—" — 4, 2, 2 ———	

Kartar Singh.
Jem. I.M.D.

Jemadar I.M.D.,
Commanding Dai Ni Bunken Sho.

CASE NO		NAME OF DIAGNOSING DOCTOR	Capt A.H.C. Coombes RAMC for Coombes				
UNIT	H.K.V.D.C.	NATIONALITY	British.	NAME AND RANK	AINSLIE, George. Private.		
NATURE OF DISEASE	DIPHTHERIA.		DATE ADMITTED	6/8/42.	DATE Died.	20/8/42. 3.35 pm.	

DATE	TREATMENT	REMARKS
6/8/42. 7/8/42.	Admitted with Tonsillitis. Gargles with Carbolic 1 in 200. 2 hourly. Aspirin Grs.20. nocte.	?.Diphtheria. Definite evidence Diphtheria Membrane.
8/8/42.	Gargles - Aspirin.	Membrane spreading.
12/8/42.	Gargles and Aspirin continued.	Membrane much increased.
15/8/42.	Gargles continued. Chloral Grs.30.at.night.	Difficulty in swallowing.
17/8/42.	Gargles continued. Chloral Grs.30. nocte.	Neck very swollen.
18/8/42.	Coramine 1.7.cc. Irrigation and cleansing of mouth with H2 O2. Chloral Grs. 3 0 at 8 p.m. Strychnine gr. 1/30 injected.	Haemorrhages into mouth.
19/8/42.	Irrigation with peroxide continued. Strychnine gr. 1/30 injected.	Further Haemorrhages into face and eye and Haematuria.
20/8/42.	Morphine gr 1/4. 12-45 p.m.	Very feeble pulse. Died 3-35 p.m.

Ainslie Dip

Pte HMVDC Coombes

E9200

CASE NO.		NAME OF DIAGNOSING DOCTOR	Capt. DHR Coombes. RAMC.		
UNIT	8 C R.A.	NATIONALITY	British.	NAME AND RANK	Gunner PORTER, Leslie.
NAME OF DISEASE	Diphtheria.	DATE ADMITTED	17/8/42.	DATE DISCHARGED	DIED 6.20 a.m. 21/8/1942

DATE	TREATMENT.	REMARKS
17.8.42	Gargles 1 in 200 Carbolic 2 hourly. Aspirin gr. 10 nocte.	Membrane on right tonsil. Diphtheria.
18.8.42	Gargles continued. Fluid diet.	Membrane on both tonsils and uvula.
19.8.42	Gargles continued.	Swelling of neck both sides.
20.8.42	Irrigations with Gargle hourly. Strychnine 1/30 gr. injected.	Increased swelling. Dyspnoea. Dysphagia.
21.8.42	3.00 a.m.	Much worse.
	6.20 a.m.	Died 21.8.42 6.20 a.m.

CASE NO.		NAME OF DIAGNOSING DOCTOR		Major K.P. BROWN, R.A.M.C.			
UNIT	12 C R.A.	NATIONALITY	British.	NAME AND RANK	Gunner SHEPPARD, Alfred C.		
NATURE OF DISEASE	(1) Pemphigus. (2) Septicaemia.	DATE ADMITTED	14.8.42.	DATE DISCHARGED	DIED 21.8.42. 0230 hrs.		

DATE	TREATMENT	REMARKS
14.8.42.	Poultices and Eusol dressings. Aspirin gr. 10 nocte.	Septic areas on forehead.
15.8.42.	Hair shaved. Hot Eusol dressings to whole head.	Face swollen. Eyes closed by swelling of lid. General condition good. T. 99.2°
16.8.42.	Hot Eusol dressings continued. Trianon 1.2 grammes. M & B 693) (Dagenan)) 2 grammes.	Condition worse Face more swollen. T.99°
17.8.42.	Dagenan 3 grammes. Eusol dressings continued. Hot applications to glands of neck.	Worse.
18th-20th	Treatment continued. Morphine ½ gr. at night.	Condition worse very restless at night. Face very swollen. Eyes closed completely by swelling. Much swelling of neck. Haemorrhagic spots all over body.
21.8.42.	2.30 a.m. Died.	

CASE NO		NAME OF DIAGNOSING DOCTOR	Capt. A.H.R. Coombes. Acting Lieut.		
UNIT	H.K.V.D.C.	NATIONALITY	British.	NAME AND RANK	JACK, Lawrence. Sergeant.
NAME OF DISEASE	Diphtheria. Chronic Enteritis.	DATE ADMITTED	5.8.42.	DATE DISCHARGED	DIED 22.8.42 3.00 p.m.

DATE	TREATMENT	REMARKS
5.8.42	Admitted from Main Ward with Tonsillitis. Suffering from Chronic Enteritis. Gargles with Carbolic 1 in 200. Bismuth gr 15 t.i.d.	? Diphtheria.
7.8.42	Gargles and Bismuth gr 15 t.i.d. Aspirin. Milk and ordinary diet.	Definite membrane on left tonsil and uvula.
9.8.42	Gargles continued. Chloral gr 30 nocte. Milk.	Membrane remains limited.
11.8.42	Gargles continued. Morphine gr ¼ nocte.	No difficulty in breathing or swallowing.
15.8.42	Gargles continued. Morphine gr ¼ nocte. Milk only.	Diarrhoea and Haemorrhoids very troublesome.
21.8.42.	Gargles continued. Milk and Fluids only. Morphine gr ¼ nocte.	Cardiac condition poor. Gradually sinking.
22.8.42	Strychnine gr ¼ injected.	Cheyne Stokes' breathing. Died 3.00 p.m.

NOTE. Previous Chronuc Diarrhoea over six months duration with considerable loss of weight and myocarditis.

CASE NO. 538

No.	8090		Name of Diagnosing Doctor		N.B. Pasa-y Jem. I.M.D.
Unit	2/14 P.R.	Nationality	Indian	Rank	Sepoy
				Name	Siraj Khan
Name of Disease	Amoebic Dysentery & Broncho Pneumonia	Date Admitted	3.8.42	Date Discharged	Died on 23.8.42. at 1.45 P.M.

Date	Treatment	Remarks
3.8.42	Frequency of stools 16 times in 24 hours, containing mucus. Associated with fever. Duration two months. Loss of appetite ++ Cough ++ . Lungs - clear. It is very weak and emaciated. Mist Saline ½ stat then ½ every hour for 6 doses. Rice water - ad lib. Hot enema c Dusol lotion 1 oz -2 pints.	
4.8.42	Stool 12 times in 24 hours, liquid and mucus nil, fever ++ Mist. saline ½ stat. (Mist stim Exp. ½ TD.S. (Stool for Exam. - E.H. + + Aspirin -gr X B.D. (Blood for M.P. - Neg. Gargles - B.D. (	
5.8.42	Stool 4 times without mucus, semisolid in consistency. fever ++ Cough ++ Mist Saline ½ daily morning. Emetine Hydrochlore gr.1 (Hypo) every day. for 6 injections. Mist Exp. Sed. ½ Tds. Aspirin - gr. X B.D. Gargle - B.D.	
12.8.42	Patient can not digest food. Cough less. fever ++ Mist carminative ½ T.D.S. (Blood for M.P. - Neg.	
14.8.42	The patient is very weak and emaciated. Fever ++ Cough ++ with pathes showing increased vocal resonance & fremitus in different parts both lungs. Crepitations on both bases present. Pulse 115 resp.24 per min. Temp. 102° at 6.30 P.M. Trianon - 4 Tab. Stat. Then 4 tab every 4 hourly T.D.S. Sugar water - at lib. Sponging - B.D.	
15.8.42	The patient is toxic and vomits everything when given by mouth. Trianon - 4 tab T.D.S. Sugar water - at lib. Sponging - B.D. Mist Bismuth ½ B.D.	
16.8.42	Condition same. The Patient refuses to take anything. Trianon - 4 Tab. T.D.S. Sugar water - at lib. Sponging - B.D.	
17.8.42	Vomiting still persists. Temp. 102.5°at 10 p.m. Mist carminative - ½ T.D.S. (Sugar water - at lib. (Blood for m.P. - Neg. sponging - B.D. (Clean the mouth. (	
	Normal Saline 2 pints (subcutaneously).	
18.8.42	Vomiting stopped; temp 100 at 10 a.m. Enema simplex (Hot) 2 pints. Quinine sulph - gr. 5 B.D. Sponging - B.D. Gargle - B.D.	

CASE NO.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	Siraj Khan
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
19.8.42	Temp. 104°F at 4 p.m. Pulse 130 - resp.30 per min. Mist Alkaline - tds Tr. Digitalis m 5 T.D.S. Sponging - B.D. Quinine sulph. gr 5 B.D.	
20.8.42	No improvement. Vomiting again present. Rpt all. Soda Bicarb (gr xvxxx) grs XL. Aqua ad 3yi - at lib.	
21.8.42	Condition is not satisfactory. Highest temp 102. Vomits everything { Pulse - 130 / Resp - 44 } per min. 8.am. Tr. Digitalis - MX Mist Alkaline ℈ TDS. Sugar Water - at lib. Quinine sulph - gr. 5 B.D. Sponging - B.D.	
22.8.42	Condition serious. Minimum temp 98.4°F. Vomiting ++ Rpt all. { Pulse 130 per min / Resp 44 per min } at 9.am.	
23.8.42	Temp 104°F at 12 noon. Pulse 145. Resp.50. Camphor in oil 1.cc (Hypo) The patient expired at 1.45 P.M. N.B. Pasary. Jem. I.M.D. Chetan Dev. Jemadar I.M.D. Commanding Dai Ni Bunken Sho.	

CASE NO		NAME OF DIAGNOSING DOCTOR	Captain A.H.R. Coombes, R.A.M.C.		
UNIT	R.E.	NATIONALITY	British.	NAME AND RANK	SINCLAIR, Harold. Sapper
NAME OF DISEASE	Diphtheria	DATE ADMITTED	16.8.42	DATE DISCHARGED	22.8.42. Died.1015hrs

DATE	TREATMENT.	REMARKS
16.8.42	Admitted.	Diphtheria
17.8.42	Gargles with Carbolic 1 in 200 every 2 hours. Aspirin gr. 10 nocte. Milk Diet.	Membrane over both tonsils
18.8.42 19.8.42	Gargles continued. Milk Diet.	Difficulty in swallowing.
20.8.42	Gargles continued. Chloral gr. 30 nocte.	Membrane spreading General condition poor
21.8.42	Irrigations of throat with Carbolic 1 in 200 Coramine 1.7.c.c. 8.p.m.	Dyspnoea commencing. Condition is worse in every way
22.8.42.	Strychnine gr. 1/30 injected. Died.	Asphyxia Cardiac Failure Died 10.15. a.m.

CASE NO		NAME OF DIAGNOSING DOCTOR	Capt. DAR Combe RAMC.		
UNIT	H.K.V.D.C.	NATIONALITY	Portuguese.	NAME AND RANK	RIBEIRO, Edward. Private.
NAME OF DISEASE	DIPHTHERIA.	DATE ADMITTED	18/8/42.	DATE DISCH.	Died 23/8/42. 2-40 a.m.

DATE	TREATMENT	REMARKS
18/8/42.	Admitted with a definite membrane over the Right Tonsil.	Diphtheria. Was a contract from a case 2 weeks previously.
29/8/42.	Gargles with 1 in 200 Carbolic. Fluids - Milk. Aspirin gr.10 nocte.	Membrane extensive on right side.
20/8/42.	Gargles continued. Fluids.	Considerable swelling of neck - Right Side.
21/8/42.	Gargles continued. Chloral grs.30 nocte.	Difficulty in swallowing.
22/8/42.	Irrigations with Carbolic. Milk only. Chloral grs. 30 nocte.	Became much weaker with Cardiac collapse.
23/8/42.	Coramine 1.7 cc. 2-30 a.m. died.	Died 2-40 a.m.

Ribeiro Mc Hinds Coombes
Dft

CASE NO. 426

No.	5117		Name of Diagnosing Doctor	KARTAR SINGH Jemadar I.M.D.	
Unit	26 Bty.	Nationality	Indian	Rank	Gunner
				Name	Din Mohd.
Name of Disease	Anaemia Secondary.	Date Admitted	26/6/1942	Date Discharged	Died at 8.P.M. on 23/8/1942.

Age:22

Date	Treatment	Remarks
26.6.42	Frequency of stools 3 weeks, weakness 2 weeks and fever. Weight (2/8/42) -110 Lungs & heart--Normal; Spleen -- Not palpable Stools for exudate: negative Blood for M.P. : negative Re. Mist aline 0ji	
27.6.42	Pain in abdomen less.	
28.6.42	Stools nil abdnormal.	
30.6.42	Re. Ferri et Ammonia citras 0ji B.D. Urine: Nil abnormal.	
1.7.42	Stools negative for ova, cyst and excudate.	
2.7.42	Tooth for extraction.	
3.7.42	Fever. Blood for M.P. Negative.	
4.7.42	Urine. Sugar and albumin Negative.	
9,7.42	Blood picture R.B.C = 1,950,000) No abnormal cell. W.B.C. = 2,400) A.D. 8 30%) C-1 = .9) P = 75) L = 25)	
11.7.42	Blood for M.P. Negative. Sputum for T.B. Negative.	
18.7.42	No fever	
20.7.42	Another tooth extracted.	
25.7.42	Again riseof temperature. Blood for M.P: Negative.	
28.7.42	Mist Ferri et Ammon citras 0ji B.D. Cod liver oil mx. B.D.	
11.8.42	Pain in the abdomen. Hot water bottle.	
12.8.42	Pain better.	
13.8.42	Oedema of eye lids. Condition is not better Urine for general examination. Nil abnormal	
15.8.42	Condition same.	
16.8.42	No change in condition.	
17.8.42	Weakness increasing.	
18.8.42	---- " -----	
20.8.42	c/o pain in the chest.	
22.8.42	Oedema increasing. Sings of heart failure.	
23.8.42	Patient is becoming more restless Air hunger. Expired at 8.p.m.	

Milk	Bottle
6.7.42	½
7.7.42	½
8.7.42	1
9.7.42	1
10.7.42	1½
11.7.42	1½
14.7.42	1
22.7.42	1
23.7.42 to 25.7.42	½
26.7.42 to 1. 8.42	1
2.8.42 to 5.8.42	2
6.8.42	1½
7.8.42	1½
8.8.42 to 12.8.42	2
13.8.42 to 28.8.42	1½

CHETAN DEV
Jemadar I.M.D.
Commanding 3-d Prisoners fo War Hospital.

Kartar Singh
Jem , I.M.D.

CASE NO		NAME OF DIAGNOSING DOCTOR	Major J.M. Officer.		
	12th Coast Regiment R.A.	NATIONALITY	English	NAME AND RANK	Gnr. PETCH, Basil
	Septic Dermatitis Toxaemia	DATE ADMITTED	23.8.42.	DATE DIED ~~DISCHARGED~~	24.8.42.

DATE	TREATMENT	REMARKS
7.8.42	Sulphur Ointment.	
10.8.42.	Eusol Baths and Dressings.	
12.8.42.	Ac. Carbol. to Sores. Sloughs removed.	Sores spreading.
13.8.42.	Eusol Baths and dressings continued.	
14.8.42.	Eusol Baths and Acriflavine Dressings.	
17.8.42.	Ac. Carbolic to Sloughs.	
18.8.42.	Acriflavine dressings.	
23.8.42.	Transferred to Camp Hospital, so as to be excused parades. Morphine gr. 1/3 given.	Toxic and suffering from loss of sleep.
24.8.42.	Died.	

(sgd) J.M. Officer, M.B. Ch.B. Edin.
Major, R.A.M.C.

CASE NO.		NAME OF DIAGNOSING DOCTOR	Captain A.H.R. Coombes, R.A.M.C.		
UNIT	Royal Navy.	NATIONALITY	British	NAME AND RANK	LAP..ORTE, Able Seaman.
NATURE OF DISEASE	Nasal Diphtheria.	DATE ADMITTED	10.8.42.	DATE DISCHARGED	6.8.42. Died 7.40.a.m.

DATE	TREATMENT.	REMARKS
10.8.42.	Aspirin gr. 10.	Admitted as Tonsillitis Very little inflammation of throat visible.
11.8.42	Gargles Pot. Permang. 1 in 5000 t.i.d.	
13.8.42	Nasal Douches with Normal Saline.	Nasal Discharge & ? Membrane on Rt. Tonsil. Nose blocked on both sides.
15.8.42	Nasal Douches continued.	
17.8.42	Douche continued. Milk Diet. Chloral gr. 30 nocte.	Nasal condition worse.
20.8.42	Douches. Fluids only.	No improvement in nasal condition.
22.8.42	Douches. Gargles with Carbolic 1 in 200 2 hourly.	Traces of spread of membrane on to Posterior Phayngeal wall
25.8.42	Strychnine gr. 1/30 8.30.a.m.	Cardiac Collapse.
25.8.42	Strychnine gr. 1/30 6.a.m.	Very weak.
26.8.42	Coramine 1.7.o.c. 6.20.a.m.	Died 7.40.a.m.

CASE NO		NAME OF DIAGNOSING DOCTOR		Major K.P. BROWN, R.A.M.C.	
UNIT	Royal Signals.	NATIONALITY	British	NAME AND RANK	PLAYER, Howard. Signalman.
NATURE OF DISEASE	Malnutrition.	DATE ADMITTED	21.7.42.	DATE DISCHARGED	26.8.42 Died 1130 hrs.

DATE	TREATMENT	REMARKS
21.7.42	Admitted from St. Teresa's Hospital.	V. thin. Frequent loose stools. Appetite good. No improvement in bowel condition
23.7.42	Calcium Carbonate gr. 180 daily.	
29.7.42	Potassium Bromide gr. 30 daily.	
4.8.42	Bemax ozs. ½ daily.	
6.8.42	Coramine .85.c.c. daily by injection. Yeast ozs. 2 daily.	Weaker. Bowel movements as before - 5 motions nightly. Losing weight. Appetite poor.
10.8.42	Thiamine ½ c.c. with Coramine by injection.	
12.8.42	Fresh Milk.	
13.8.42 – 25.8.42	Treatment continued.	Progressive deterioration in general condition. Unable to eat. Sleeping poorly Steadily getting weaker.
26.8.42	09.30 hrs. became comatose. Gradual weakening of respiration and heart. Death 1130 hrs.	

CASE NO.

No.	658		Name of Diagnosing Doctor		H.A.V.D.C. Major J. Durran
Unit	Royal Rifles of Canada	Nationality	Canadian	Rank	Fifth, M. (Private)
				Name	
Name of Disease	Acute Colitis.	Date Admitted	27.8.42.	Date Discharged	Death: 28.8.42.

Date	Treatment	Remarks
27.8.42.	On admission. Very weak & toxic - T.103° Incontinence of faeces : B.O. several every hour. Muttering - Delirious - Restless. Fluids † † Mist. Sod. Sulph 3ß 2-hly. Pot Brom. Chlorsilized aa ƒ ss 4.hly.	Stretcher Case. very toxic and delirious on admission.
28.8.42	Muttering Delirium during night. Very restless. Not smitened by bromide chloral aa ƒ xxv 1. Hyoscine g 1/100 myth Slept after hyoscine 2 - 3 hours. 9.0 a.m. Condition this morning much the same. Pulse 130. Heart much weak. sachet 4hr with mixture Tongue dry. Vit. B. 10 mg 1 M. Lungs - N.a.B. Spleen - Not palpable. Stop sulph. Stools - semi faecal- mucus Glucose drinks. 2.0 pm. Blood - no malaria parasites seen. White blood count 6,800 Polymorph. 26% Lymphocytes 68% Quinine p ℞ 4. hr. 4.0 pm. Seems slight improvement. taking fluids copiously. 6.30 p.m. Still taking fluids freely. 7.0 p.m. Sudden collapse. Died. J. Durran, Major, HKVDC. 28/8/42.	

Date	Bed No. 12	Name of Diagnosis	Captain A.H.R. Coombes, R.A.M.C.
	Royal Corps of Signals.	Nature of Illness	British
			Name and Rank
			HALSTEAD, Thomas. Signalman.
25.8.42	Diphtheria.	Date 4 days after	Date Diagnosed 29.8.42.

TREATMENT

Date		Remarks
25.8.42	Admitted. Gargles 1 in 5000 Pot. Permang. 2 hourly. Aspirin gr. 10 nocte. No Diphtheria antitoxin available.	Membrane on Rt. tonsil. Adenitis of neck.
26.8.42	Gargles. Chloral gr. 15 nocte.	Membrane spreading.
27.8.42	Gargles. Aspirin gr. 10 nocte.	Membrane both tonsils and uvula.
28.8.42	Gargles. Chloral gr. 30 nocte.	Dyspnoea marked. Swelling of neck +
9.8.42	Gorgoline 1.7.c.c. injected 4.30.a.m. Irrigations with Pot. Permang. 1 in 5000. Died 5.4.p.m.	Several attacks of acute Dyspnoea. Asphyxia.

MEDICAL CASE SHEET

Regt'l No.	Rank	Surname	Christian Name	Age	Service
C-65270	Rfn.	Pomeroy	Robert	25	2 years.

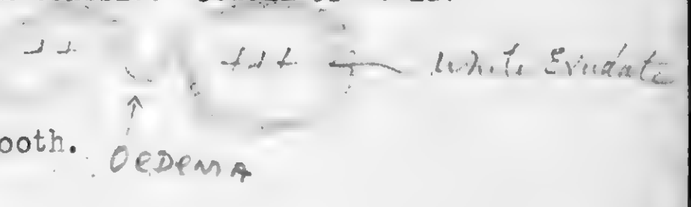
Unit	Admitted
The Royal Rifles of Canada	1830 hrs 29/8/42.

Diagnosis -- Membranous Tonsillitis (Streptococcal) and Beri-Beri.

Hong Kong
29/8/42 - Complained of - Sore Throat. Says it came on yesterday.

Patient's Past History - Nil.

On examination - Pale, Ill-looking man with markedly offensive breath. Right and left tonsillar regions very much enlarged and Oedematous. White, gummy-looking exudate widespread over both tonsils. Oedema of uvula.



Tongue- Slightly cracked and rather smooth.
Heart - Sounds distant and feeble.
Pulse Rate - Rapid.
Abdomen - Nill abnormal palpable.
Lungs - Clear.
Central Nervous System - Knee and ankle jerks both absent.
Vibration sense absent in both Legs up to the hips.

1920 hrs. Treatment - Left peritonsillar abscess incised 20 minutes after a 1/4 gr. of Morphia had been given.
30 mg. Thiamin Chloride intravenously.
Streptococcide tablets 8 (0.4 grs.) tonight.
Food - glucose or sugar drinks freely.
Strict recumbent position in bed.

Placed on Dangerously ill List.

30.8.42. Swab - Laboratory Report -- Streptococci present + Scanty B. Hoffman Bacilli present. No Vincent's organisms seen. No Kleb's Loeffler's Bacilli seen.

Urine - Laboratory Report -- No albumen present.

Slept fairly well. Throat swelling this morning appeared as large as ever.

Heart - First sound very weak.
Pulse Rate - Still very rapid.

Treatment - Left tonsillar region again incised.
30 mg. Thiamin chloride given intravenously. Streptococcide tablets 8 (0.4 grm). Sugar drinks. Hot irrigations to the throat. Ice pack to neck.

1900 hrs. Throat still very swollen. Right side incised. No pus evacuated. Portions of the thick membrane clinging to both tonsils, removed. Nostrils are plugged with purulent discharge. Some membrane appeared down the nose to-day, when the patient blew it. (Morphia, 1/4 grs., given at 1900 hrs.)

2300 hrs. Some difficulty with breathing. Headpropped forward by pillows. Good airway assured.

31-8-42
Morning Fair night only.
Pulse Rate - very rapid
Heart - Sounds very weak.
Throat - Slightly less swollen.

Treatment - Fluids +++. Glucose.
Diphtheria antitoxin 20,000 units given intramuscularly at 0915 hrs, purely as a precautionary measure.

41208

CASE NO.

No.	674		Name of Diagnosing Doctor		Major G.F. Harrison R.A.M.C.
Unit	R.M. Canada	Nationality	Canadian	Rank	Rifleman
				Name	A. Pomeroy
Name of Disease	1.Diptheria 2.Beri-beri 3.Heart Failure	Date Admitted	29.8.1942	Date Discharged	Died 1/9/42 at 4 A.M.

Date	Treatment	Remarks
29/8/42	Left Peritonsillar Abscess incision, after 1/4 gr Morphia given 1/2 an hour before. 30 mg Thiamin Chloride intravenously. Streptococcide tablets 8. to-night. Food - glucose ++ Fluids +++ Strict recumbent position in bed. PLACED ON DANGEROUSLY ILL LIST	Stretcher Swollen. Inflammed tonsils. Dangerously ill.
30/8	Lab. Report Streptococci present + Scanty B.hoffman Bacilli present. No Vincents organisms seen. No Klebs Loeffles Bacilli seen. 30 mg Thiamin Chloride - intravenously. Streptococcide Tabs. 8. Hot Irrigation to throat. Ice pack to neck.	Exremely ill.
31/8	Fluids +++ Glucose Diptheria Antitoxin 20,000 Units given intravenously.as a precaution (in spite of negative Lab. Reports). - 30 mg Thiamin Chloride Given intravenously. - Streptococcide Tablets 12 (6.0 grm) - Hot irrigation. - Digoxin M35 at 1 pm. 5 pm. & 11 pm. . Lab.Report No Klebs Loeffles Bacilli seen. Streptococci + Scanty B. hoffman bacilli present. Scanty Vincents organisms present.	
1/9/42	4 a.m. Patient died.	

81209

30 mg. Thiamin Chloride given intravenously.
To have streptococcide tablets 12 (0.6 grm) today. Continue hot irrigations to throat and ice pack to neck.
In addition, Digoxin M35 at 1100, 1700 and 2300 hours.

Laboratory Report on Second throat swab-
No Kleb's Loeffler's Bacilli seen.
Streptococci +.
Scanty B. Hoffman's present.
Scanty Vincents organisms.

1900 hrs.. Slightly incoherent in speech. Mind is wandering. Airway much clearer than last night. Less pain in throat. Pulse rate still more rapid. Heart sounds just as weak.

2300 hrs. Rather restless. 1/6 gr. Morphia given with good effect.

1-9-42. - 0400 hrs -- Patient died.

POST MORTEM

Results of Post Mortem Examination:

Both tonsils covered with some membrane. Thin membrane extended down trachea as far as vocal chords (Specimen taken).
Lungs - Some postmortem congestion.
Heart - Normal size. Valves - normal. Muscle appeared slightly more flabby than normally.
Aorta showed slight, early atheromatous changes.
Spleen - Normal in size and consistency.

Conclusion:

1. It is impossible to exclude, with certainty, the presence of diphtheria without any means of culturing the Throat Swab.

2. Against diphtheria were:
   (a) the high temperature.
   (b) The lack of any previous case.
   (c) The typical smell of Vincents Angina
   (d) The absence of albumen in the urine.
   (e) The absence of Kleb's Loeffler's Bacilli in the direct smear.

3. It would appear that this patient had Cardiac Beri-beri for the following reasons:
   (a) The presence of other cases of Beri-Beri.
   (b) The tic-tac nature of the heart sounds, which were weak and distant since first admission.
   (c) The absence of reflexes and vibration sense in both legs - evidence of neuritis.

4. The combination of Cardiac Beri-beri and intense Toxaemia would, in any case, have a bad prognosis, and the fatal outcome of this case was suspected on admission.

Harrison,
Major, R.A.M.C.

1-9-42.

CASE NO		NAME OF DIAGNOSING DOCTOR		Rodrigues, A.M.	
UNIT	R.A.S.C.	NATIONALITY	English.	NAME AND RANK	S/Q.M.S. SMITH, Robert.
NAME OF DISEASE	Enteritis and Myocarditis.	DATE ADMITTED	25.8.42.	DATE Death ~~DISCHARGED~~	31.8.42.

DATE	TREATMENT	REMARKS
25/8/42.	Admitted with diarrhoea, showing blood and mucus in stools. History of previous cardiac attacks. Morphia ¼gr.at night.	Diet - Fluid.
26/8/42.	Stools less overnight - good nights sleep. Temp.100.2. Kaolin 4 times per day. Dyspnoea on exertion and some vomiting.	Pulse 98.
27/8/42.	20-30 stools through the night - condition worse. Morphia given at bedtime.	Toast (one) given with fluid.
28/8/42.	Tongue dry and general condition worse - great weakness. Saline given by mouth all day.	
29/8/42.	Condition unchanged. Treatment same.	
30/8/42.	Condition slightly worse. Morphia at night. Respirations forced.	Coramine 1 cc. given.
31/8/42.	Vomiting worse and dyspnoea and weakness extreme on exertion. Sod.Bicarb. gr.5 given S.O.S. and saline continued. Coramine given at 9 a.m. 4 p.m. and 9 p.m. Patient restless and noisy. Morphia gr.¼. by injection 10.30.p.m.x Died 11.50. p.m.	

A.M. Rodrigues, M.B. B.S.
Lieut., H.K.V.D.C.

B. Dyspnoea
S/Q.M.S. Smith

Rodrigues

		NAME OF DIAGNOSING DOCTOR	RODRIGUES. A.L.		
UNIT	5th A.A. R...	NATIONALITY	English	NAME AND RANK	Gunner HUGHES, Thomas.
NATURE OF DISEASE	Enteritis.	DATE ADMITTED	[illegible].8.42	DATE of Death ~~DISCHARGED~~	31.8.42.

DATE	TREATMENT	REMARKS
8.8.42	Admitted with diarrhoea and abdominal pain. Temp 100° F. Pulse 90. Kaolin ozs. ½ t.d.s.	Diet - Liquid.
9.8.42	12 stools passed during the night and same amount during the day. General Condition fair - temperature normal. Saline solutions given by mouth. 1 pint for the day.	
30.8.42	Condition deteriorated. 15 stools for the night. Patient in cold sweats. 2 pints Saline given for the day. 7.15.p.m. Coramine inj. given 1.c.c. Condition worsened during evening. Extremities cold, respiration rapid and pulse practically not felt at the wrist. 9-30.p.m. Coramine Inj. 1.c.c. given. 10.p.m. Morphia ¼ gr. by mouth. Slight rest from 10.30.p.m. to 11.30.p.m. but patient restless later, condition worsening.	
31.8.42	Becoming moribund at 12.30.a.m. Died 1.20.a.m.	

(sgd) A.L. Rodrigues. Lieut.
H.K.V.D.C.

CASE NO		NAME OF DIAGNOSING DOCTOR	Rodrigues, A.M.		
UNIT	Middx.	NATIONALITY	English.	NAME AND RANK	Private MERRY, William.
NATURE OF DISEASE	ENTERITIS.	DATE ADMITTED	19/8/42	DATE DISCHARGED	Died 2/9/42.

DATE	TREATMENT	REMARKS
19/8.	Admitted with Diarrhoea and Abdominal pains. Stools - Blood XXX Mucous XXX. Mag. Sulph. gr.ii b.d.	Diet - liquid.
20/8.	Kaolin 6 times for the day. Stools 10 daily. Temp 103° F.	
21/8.	Stools still with blood and mucous. Kaolin continued for three more days.	
25/8.	Condition weak. Dehydrated. Saline given 2 pints for day.	
26/8.	15 stools for the night. Condition very weak. Saline continued.	Powdered milk 1 pint.
27/8.	Slightly less stools. Saline continued. Temp 97.4°F.	Fresh milk 1 pint.
28/8. 29/8. 30/8. 31/8.	Condition unchanged - saline continued. Very weak and dehydrated - temp 101.4°F. Injection Coramine p.m. Saline continued.	Fresh milk and 1 slice toast.
1/9.	Kaolin and saline during the day. Morphia ¼gr. at night.	
2/9.	Respiration 16 - pulse 120 9.00 a.m. Respiration 20 - pulse 130 10.00 a.m. Rapidly sinking. Died 12.55 p.m.	

Cuthbertson Lieut. R.A.M.C.

Pte Merry. Rodrigues.
Dysentery

28200

CASE NO.	Bed No. 1.	NAME OF DIAGNOSING DOCTOR	Captain A.H.R. Coombes, R.A.M.C.		
UNIT	8th Coast Regt. R.A.	NATIONALITY	British	NAME AND RANK	STIRLING, Thomas. Gunner.
NATURE OF DISEASE	Faucial Diphtheria.	DATE ADMITTED	26.8.42.	DATE DISCHARGED	Died 2.9.42.

DATE	TREATMENT	REMARKS
26.8.42	No antitoxin given.	Membrane over Rt. tonsil.
27.8.42	Gargles with Pot. Permang. 1 on 5000. Aspirin gr 10 b.d.	Membrane more extensive.
28.8.42	Gargles continued. Aspirin gr 10 nocte.	Membrane over both tonsils uvula.
29.8.42	Gargles continued. Aspirin gr. 10 nocte. Fluids only.	Membrane spreading. Hard palate involved Worse. Swelling of neck + + +
30.8.42.	Irrigations with Pot. Permang 1 in 5000. Aspirin gr. 10 b.d.	
31.8.42.	Irrigations with Carbolic 1 in 200 Coramine 1.7.c.c. injected.	Swelling of Neck very considerable and condition worse.
1.9.42	Irrigations continued. Strychnine gr. 1/30 injected 8.p.m.	
2.9.42.	------	Much worse. Difficulty in breathing. Oedema of neck + + +
	Died 8.35.a.m.	

CASE NO	12	NAME OF DIAGNOSING DOCTOR	Captain A.F.H. Coombes, R.A.M.C.		
UNIT	4th Coast Regt. R.A.	NATIONALITY	British	NAME AND RANK	ANYON, Kenneth. Gunner.
NAME OF DISEASE	Faucial Diphtheria.	DATE ADMITTED	25.8.42	DATE DISCHARGED	Died 2.9.42.

DATE	TREATMENT	REMARKS
25.8.42	Gargles Pot. Permang. 1 in 5000 2 hourly. Aspirin gr. 10 nocte. No antitoxin.	Left faucial Diphtheria.
26.8.42	Gargles continued as above. Chloral gr. 15 nocte.	definite membrane & spreading. feels v. ill. grey look.
27.8.42	Gargles. Aspirin gr. 10 9.p.m.	membrane extends to other fauces and uvula.
28.8.42	Gargles.	
29.8.42	Gargles. Aspirin gr. 10 nocte.	membrane still spreading.
30.8.42	Irrigations with Phenol 1 in 200. Fluids only. Aspirin gr. 10 nocte.	Difficulty in swallowing commenced.
31.8.42	Irrigations. Fluid diet only. Aspirin gr. 20 nocte.	Becoming worse V. difficult to swallow. High temp. 104.6
1.9.42	Irrigations continued. Atropine and Morphine ¼ injected 9.p.m. gr. 1/60.	Condition very poor. Pain in Chest.
2.9.42	Died 5.30.a.m.	Cardiac Failure.

CASE NO	22	NAME OF DIAGNOSING DOCTOR	Captain A.V.R. Coombes, R.A.M.C.		
UNIT	Royal Navy.	NATIONALITY	British	NAME AND RANK	WILKINSON, William Ernest. Able Seaman.
NAME OF DISEASE	Faucial Diphtheria.	DATE ADMITTED	30.8.42.	DATE DISCHARGED	Died 2.9.42 11.40.a.m.

DATE	TREATMENT	REMARKS
30.8.42	No antitoxin given (Nil available). Admitted night.	Rt. Faucial Diphtheria.
31.8.42	Gargles Carbolic 1 in 200 2 hourly. Milk and Rice.	Swab suggestive with beaded Diphtheroids.
1.9.42	Gargles continued. Fluids only. Morphine gr. ¼ by mouth.	Membrane over Rt. ant. faucial pillar
2.9.42	Irrigations to throat. Fluids. Coramine 9.p.m. 1.7.c.c. Died - Bronchopneumonia. Diphtheria (faucial).	General condition very poor. Broncho-pneumonia. Cyanosed. Dyspnoea + Died 11.40.p.m. 2.9.42.

CASE NO	2	NAME OF DIAGNOSING DOCTOR	Captain A.H.R. Coombes, R.A.M.C.		
UNIT	1st Bn. The Middx. Regt.	NATIONALITY	British	NAME AND RANK	PARTING, Arthur David. Sergeant.
NAME OF DISEASE	Faucial Diphtheria.	DATE ADMITTED	25.8.42	DATE DISCHARGED	Died 4.30.a.m 3.9.42

DATE	TREATMENT	REMARKS
25.8.42	No antitoxin on admission Gargles Pot. Permang. 1 in 5000 2 hourly. Aspirin gr. 10 nocte.	Diphtheria Faucial and bilateral. Severe. Membrane spreading and secondary infection marked
26.8.42	Gargles continued. Aspirin gr. 10 nocte.	
27.8.42	Gargles.	
28.8.42	Gargles. Aspirin gr. 10 nocte.	Membrane worse. Uvula involved and posterior pharyngeal wall. Swelling of neck
29.8.42	Gargles. Fluids only.	Condition not improving. Swelling of neck worse.
30.8.42	Irrigations Pot. Permang. 1 in 5000 2 hourly. Morphine gr. ¼ per os. 9.p.m. Fluids.	t. up. P. rapid poor volume.
31.8.42	Irrigations with Carbolic 1 in 200 hourly. Milk only. Aspirin gr. 10 b.d.	Dyspnoea + + Unable to swallow. Swelling of neck + + became delirious.
1.9.42	Irrigations continued. Unable to swallow fluids.	
2.9.42.	Irrigations. Strychnine. 9.p.m. gr. 1/30.	Coma.
3.9.42	Died 4.30.a.m.	death 4.30. a.m.

CASE No.	15	NAME OF DIAGNOSING DOCTOR		Capt. in A.M.R. Coombes, R.A.M.C.	
UNIT	Royal Engineers	NATIONALITY	British	NAME AND RANK	NELSON, William. Corporal.
NATURE OF DISEASE	Nasal & Faucial Diphtheria.	DATE ADMITTED	28.8.42.	DATE DISCHARGED	Died 5.a.m. 4.9.42.

DATE	TREATMENT	REMARKS
29.8.42	Admitted from Main Ward where he had been next to a contact case of Diphtheria. No Antitoxin given (none available). Gargles 2 hourly. Nasal douches with N. Saline 2 hourly. Aspirin gr. 10 nocte.	Faucial and Nasal Diphtheria. Severe.
29.8.42	Gargles. Nasal Douches. Aspirin gr. 10 nocte. Dressing to le[illegible].	[illegible]everane over Rt. tonsil -- and left nostril [illegible]
30.8.42	Gargles. Mentholatum to Rt. Nostril. Chloral gr. 15 nocte.	General condition very poor.
31.8.42	Gargles. Mentholatum to nose.	Diphtheritic condition static but general state worse.
1.9.42	Irrigations to nose and throat.	Much worse. Semi comatose condition.
[illegible].9.42.	Gargles to throat. Irrigations to nose.	Swelling of face marked.
3.9.42.	Gargles. Strychnine gr. 1/30. Died 5.a.m. 4.9.42.	Pulse v. weak Cardiac Failure.

CASE NO.	Bed No. 4.	NAME OF DIAGNOSING DOCTOR	Captain A.M.R. Coombes, R.A.M.C.				
UNIT	Royal Engineers.	NATIONALITY	British	NAME AND RANK	ALLAM, Arthur Godfrey Sapper		
NATURE OF DISEASE	Diphtheria Faucial Severe.		DATE ADMITTED	18.8.42	DATE DISCHARGED	Died 2.5.p.m. 4.9.42	

DATE	TREATMENT	REMARKS
18.8.42	Admitted. No antitoxin available. Gargles. Aspirin gr. 10 nocte.	Severe bilateral faucial infection.
20.8.42	Gargles. Aspirin gr. 10. nocte.	Infection spreading.
22.8.42	Gargles. Fluid diet.	Membrane over uvula and Rt and Lt. Tonsils.
24.8.42	Gargles. Fluids only.	Membrane still extending. Condition poor. Very weak.
25.8.42	Irrigations. Chloral gr. 15 nocte.	Still has pyrexia. Part of membrane removed. Slight improvement.
27.8.42	Irrigations continued.	Membrane less. Feels better.
28.8.42	Gargles.	Very improved throat. Membrane disappearing. Still improving.
30.8.42	Gargles.	
31.8.42	Gargles. Thiamin 10 Milgrammes.	General condition better.
1.9.42	Solid Food.	Membrane cleared but palatal palsey.
3.9.42	Fluids only. Irrigations throat. Coramine 1.7.c.c.	Myocarditis. Heart Failure.
4.9.42	Cardiac collapse. Strychnine gr. 1/30. Adrenaline m.10 (1 in 1000).	Worse. Died 2.5.p.m.

88203

CASE NO		NAME OF DIAGNOSING DOCTOR	Major K.P. BROWN, R.A.M.C.		
UNIT	Royal Scots.	NATIONALITY	British	NAME AND RANK	CHRISTIE, William. Private.
NAME OF DISEASE	1. Broncho-Pneumonia. 2. Paralysis of Diaphragm following Diphtheria	DATE ADMITTED	5.8.42	DATE DISCHARGED	5.9.42 Died 2155 hrs.

DATE	TREATMENT.	REMARKS
5.8.42	Transferred to Camp Hospital from St. Teresa Hospital as a convalescent Diphtheria. patient. Lying flat in bed.	Palatal paralysis and some Laryngeal paralysis. Occasional cough which had no explosive character. Pulse and temperature normal.
9.8.42	Allowed to sit up for meals.	
14.8.42	Allowed to sit up in chair ½ hour daily.	
16.8.42	Returned to bed to lie flat.	Pulse rate rose to 100.
18.8.42	Continue treatment. Milk.	
25.8.42	Continue treatment.	Pulse 80 lying flat.
30.8.42	Head and shoulders raised on back rest.	Pulse 74. Cough more frequent and sputum difficult to raise. c/o weakness of hands. Grip fair in both hands.
1.9.42	Continue.	Pulse 84. Weakness of arms now marked. Frequent and ineffective cough. Sputum raised with great difficulty, leaving him exhausted with the effort.
3.9.42	Continue.	Pulse 92 morning. Pulse 96 evening.
4.9.42	Continue.	Pulse 84 morning. Weakness of Pulse 92 evening. arms increasing. Cough more difficult. Chest - Moist sounds ate bases of lungs.
5.9.42	Continue. Attack of breathlessness at 1800 hours. Pulse rate 136. Coramine 1.7.c.c. by injection without improvement. 2155 hours Died.	Unable to raise arms as high as chest. Attempting to take food produces fit of coughing with production of sputum after much exhausting effort. Pulse 104 morning. Pulse 136 evening.

CASE NO	--	NAME OF DIAGNOSING DOCTOR	Captain A.H.R. Coombes, R.A.M.C.				
UNIT	Royal Navy	NATIONALITY	British	NAME AND RANK	HUTCHINSON, George. Petty Officer.		
NAME OF DISEASE	Diphtheria Faucial Rt.	DATE ADMITTED	31.8.42	DATE DISCHARGED	Died 5.a.m. 5.9.42.		

DATE	TREATMENT	REMARKS
31.8.42	Admitted. No Antitoxin given (None available). Gargles carbolic 1 in 200 2 hourly. Aspirin gr. 10 nocte.	Faucial side. Diphtheria Rt.
1.9.42	Gargles continued. Aspirin gr. 10.	Membrane spreading. Fever.
2.9.42	Gargles continued. Cascara Liq. ozs. 1 nocte. Liquid diet only.	Vomiting 9.a.m. B.N.O.R.
3.9.42	Irrigations Carbolic 2 hourly. Fluids only.	Membrane increased. Both fauces involved.
4.9.42	Irrigations continued. Morphine gr. 1/6 by mouth.	Dyspnoea. Difficulty in swallowing marked.
5.9.42	Died 5.a.m.	Cardiac and Respiatory collapse.

CASE NO	Bed No. 2	NAME OF DIAGNOSING DOCTOR	Captain A.N.R. Coombes, R.A.M.C.		
UNIT	Corps of Military Police.	NATIONALITY	British	NAME AND RANK	PRATT, Walter. Lance-Corporal.
NATURE OF DISEASE	Diphtheria.	DATE ADMITTED	31.8.42	DATE DISCHARGED	Died 5.9.42 8.30.p.m.

DATE	TREATMENT.	REMARKS
31.8.42	No antitoxin given (Condition considered too extreme when available on 5.9.42). Gargles carbolic 2 hourly. Morphine gr. ¼ nocte.	Throat infected. Patch of Membrane over Right Tonsil Clinical Diphtheria.
1.9.42	Gargles.	Membrane spreading over Rt side of hard palate.
2.9.42	Gargles. Fluids only.	
3.9.42	Irrigations to throat. Morphine gr. ¼ per os.	Condition very poor. No resistance.
4.9.42	Irrigations continued. Strychnine gr. 1/30 7.p.m.	Fever 104 Delirious. Very weak.
5.9.42	Irrigations. Coramine 1.7.c.c.	Unable eat or drink. Mouth Septic. Rapidly dying.
		Died 8.30.p.m.

NOTE. Had been a bedridden patient in Hospital for 2 months previously with dry Beri-Beri.

CASE NO.

No.	683		Name of Diagnosing Doctor		J.E. Smyer Major, R.A.M.C.
Unit	R.R.C.	Nationality	Canadian	Rank	Lfn.
				Name	Ross, C.M.
Name of Disease	Cellulitis scrotum and Perineum	Date Admitted	31.8.42.	Date Discharged	Death 6.9.42.

Date	Treatment	Remarks
31.8.42.	Admitted from North Point Camp with extensive cellulutis of the perineum and scrotum with areas of necrosis. Treated by rest, andeusol dressings.	Stretcher
3.9.42	Started intractable nose-bleeding. Mucous of right nares oedematous and sloughing with general ooze. Nose plugged with eusol gauze. Morphia gr 1/4 given.	
5.9.42	Has improved as regards with nose-bleeding but the condition of the scrotum and perineum is getting worse. ℞. Sulphthiazol. Vitamin capsules.	
6.9.42	Condition worse. No reaction to treatment while in Ward 1 today. Given Saline 400 c.c. Given Coramine 2 c.c. Sulphathiyole. Died 3.44 p.m. 6.9.42. James W. Anderson Major 6/9/42.	

CASE NO		NAME OF DIAGNOSING DOCTOR	RODRIGUES. A.M.				
UNIT	5th A.A. Regiment R.A.	NATIONALITY	English.	NAME AND RANK	BARKER, Alfred. Gunner		
NAME OF DISEASE	Enteritis & Septicaemia		DATE ADMITTED	27.8.42	DATE Death ~~Discharged~~	6.9.42	

DATE	TREATMENT.	REMARKS
27.8.	Admitted with hyperpyrexia, diarrhoea and abdominal pains. Stools Bl.+ + M. + + + P.M. Temp. 105 F.	Diet Liquid.
28.8.	Eleven Stools during night. Kaolin given four times a day. Saline for the day. Quinine twice daily.	
29.8.	20 stools during the night. Kaolin and Saline continued.	
30.8.	Temp. maintaining high. Aspirin given b.d. with Kaolin and Saline. Morphia at night.	
31.8.	Placed on Seriously Ill List. Mutiple abscesses showing on buttocks and arms. Fomented.	
1-3.9.	Kaolin and Saline continued. Dressings for abscesses which are draining freely. Patient drowsy with constant temperature. Hiccoughing often. Temperature 101F.	
4.9.	Temperature 98.9F but Pulse 100. Stools - no change in frequency but improved in quality - no blood or mucous.	
5.9.	Hiccoughing worse - general condition poor. Put on Dangerously Ill List. Morphia gr. ¼ at night - Saline continued - Temp. 99F - Pulse 105.	
6.9.	Condition deteriorated - Saline given all day by mouth. Pulse 110 - Temp. 97F - Morphia Gr. ¼ by mouth during day, with Sodi. Bicarb. to ease the hiccough - which was relieved but general condition got much worse and patient died at 9.10.p.m.	

(sgd) A.M. Rodrigues.
Lieut., M.K.V.D.C.

Rodrigues

Gnr Barker
R Dysentery

E6200

CASE NO		NAME OF DIAGNOSING DOCTOR	Captain A.N.R. Coombes, R.A.M.C.		
UNIT	12th Coast Regiment R.A.	NATIONALITY	British	NAME AND RANK	DEAKIN, A. Gunner
NAME OF DISEASE	Chronic Enteritis. Diphtheria.	DATE ADMITTED	30.8.42	DATE DISCHARGED	8.9.42 Died 4.55.a.m.

DATE	TREATMENT	REMARKS
30.8.42	No antitoxin given (none available). Gargles 2 hourly. Morphine gr. ½	Carried in. Collapsed with sore throat and general weakness.
31.8.42	Gargles. Kieselguhr oz. 1 t.i.d.	Very emaciated. Diarrhoea. Chronic
1.9.42	Gargles.) continued. Kieselguhr)	Membrane not extensive. Throat -
2.9.42	Gargles etc., continued.	
4.9.42	Coramine 1.7.c.c. and continue treatment.	Throat improved. General condition very weak.
5.9.42	Coramine 1.7.c.c. and C.T.	
6.9.42	Strychnine gr. 1/30 and C.T.	Diarrhoea very troublesome and continuous.
7.9.42	Morphine gr. ¼ S.C.I. and C.T. Died 4.55.a.m. 8.9.42.	Much weaker. Delirious. Died.

NOTE. Previous Acute Dysentery on 3 occasions, and Chronic Diarrhoea for over 3 months.

CASE NO.

No.	477		Name of Diagnosing Doctor	Rank	Major G.F. Harrison R.A.M.C.
Unit	R.A. of Can.	Nationality	Canadian	Name	Gunter, N.
Name of Disease	1. Diphtheria 2. Heart Failure	Date Admitted	24.8.42	Date Discharged	Died.

Date	Treatment	Remarks
24.8.42	Pot. Permag. Gargles 10 mg. Thiamin Chloride	Stretcher
25.8.42	Swab from throat shows "No K.L.B... or Vincent's organisms. Streptococci present. Urine - No albumen present.	Exudate on Both tonsils.
26.8.42		Throat improving.
27.8.42	10 mg. Thiamin Chloride given on alternate days.	
29.8.42	Hot irrigations frequently. Recumbent position. All precautions for diphtheria.	Sore throat returned Membrane Right tonsil
3.9.42	Throat Swab - No. K.L.B. or Vincents Organisms. Numerous organisms present. Fusiform bacillus & ? C/hoffman. No spirelli seen. Urine Test for Albumen - Negative.	
4.9.42	10,000 units Diphtheria Anti-Toxin given intra - muscularly, as a precaution. Ice-pack to neck. Multi-vit Capsules 2 per day. Streptococcide tablets 6 per day. (No further Anti-Toxin available)	
5.9.42	Lab: Report on Urine - Albumen present, pus cells & tubular casts present. Sugar drinks, fluids, extras - streptococcide tablets 6 per day.	
6.9.42	Stop streptococcide. Irrigations & gargles as before. Throat Swab - Scanty diphtheroid bacillus present, not showing meta-chromatic granules nor resembling C hoffmani. No Vincents organisms seen.	
8.9.42		Thick membrane still present.
9.9.42		Heart condition appears better.
9.9.42	Raise end of bed on blocks. Heart condition worse. 9 p.m. - Pulse extremely feeble. 9.45 p.m - Patient died. G.F. Harrison, Major, R.A.M.C.	Conditon Critical.

CASE NO. 541

No.	541		Name of Diagnosing Doctor		Major G.F. Harrison, R.A.M.C.
Unit	W. G.	Nationality	Canadian	Rank	L/Cpl.
				Name	Whillier, W.C.
Name of Disease	Diptheria Beri Beri Heart Failure	Date Admitted	5/9/42	Date Discharged	Died.

Date	Treatment	Remarks
5.9.42	Gargles, throat irrigations. Strict recumbency in bed. 10 mg. Thiamin Chloride every day.	Stretcher Very thin and emaciated.
6.9.42	Anti-phlogistine to swelling in right cheek (Says "has had burning feet for three weeks") Urine test for albumen - Negative. Throat Swab - Scanty diphtheroid bacillus present. Not showing meta-chromatic granules nor resembling C hoffmani. No Vincents organisms seen.	Whole mouth & throat coated with yellow gummy exudate.
8.9.42	Ensol irrigations to mouth. Sulphapyridine - ("Trianon") 6.0 Gms. per day. Inhalations 4 times to-day. Lab. Report on Urine - Albumen present and renal epithelium.	
9.9.42	30 mg. Thiamin Chloride intravenously. 15 grams of glucose in 20 cc. (50% glucose) given intravenously. Morphia grains ¼ - rectal salines - Soludagenham 1.0 gram intramuscularly. 2 p.M. Raise end of bed on blocks. 2.15 p.m. Coramine 2 cc. given intravenously Hot water bottle over the heart. 3.00 p.m. Patient died. G.F. Harrison, Major, R.A.M.C.	Condition worse. Pulse rate very rapid Difficulty in swallowing. Condition Critical.

CASE NO		NAME OF DIAGNOSING DOCTOR	Surg.Lieut. C.A. Jackson, R.N.V.R.		
UNIT	Royal Marines.	NATIONALITY	British.	NAME AND RANK	JEFFRIES. R. Marine. Age 23.
NAME OF DISEASE	(i) Acute Bacillary Dysentery. (ii) Diphtheria.	DATE ADMITTED	30.7.42.	DATE DISCHARGED	Died 1830 hrs 9.~~9~~.42

DATE	TREATMENT.	REMARKS
13.8.42	Transferred from acute diphtheria ward. Convalescent from a faucial infection (severe) not treated with antitoxin.	Bed. Full Diet. Gargles t.d.s.
20.8.42	Myocardial condition satisfactory. c/o blurred vision, no pareisis of intrinsic muscles of eye:- Discs. Left shows on temporal side, a white patch having in lower left segment a black triangular area of pigmention.	To sit up for meals.
23.8.42	No improvement or change in visual condition developed. Paralysis of left palate, nasal voice and difficulty of swallowing.	
30.8.42	Increasing difficulty in speaking, food "stick in throat" and fluids regurgitate. Appetite good.	Strict bed. Sitting up daily.
3.9.42	c/o Diarrhoea, loss of appetite, pains in stomach - stools loose faeculent - no B or M.	Fluids only.
4.9.42	Restless night with twelve bowel actions, dyspnoea much worse. Stool - B & M present, typical dysentery stool.	
5.9.42	T.101. P.109/min. Tongue moist. Taking fluids well. B.open x 8 nocte. No response to K.iii	Rx. Kiii Water pints viii daily.
6.9.42	Now appears very toxic, NOT dehydrated but rapidly becoming emaciated. T.100.6 P.120	Milk pints 1 daily.
7.9.42	Tenesmus ++. B.O.5. Very exhausted. Palatal pereisis makes taking fluids difficult - Morphia gr. 1/3 nocte. Sulphurthiazole G.2 stat. Gl for two doses.	Saline dr. 1 in pints 1. 2 pints daily.
8.9.42	No response to chemo-therapy - very light headed and restless. Profoundly toxic. B.N.O. nocte. Morphia 1/3 nocte.	
9.9.42	Lapsing into periods of unconsciousness. Aphonia complete Vomiting fluids. Failure of peripheral condition. DIED 1830 hrs. Death being due to ACUTE BACILLARY DYSENTERY.	

Case No.		Name of Diagnosing Doctor.	RODRIGUES.A.M.		
Unit	Middx. Regt.	Nationality.	English	Name and Rank	LEONARD, Albert. Private.
Name of Disease.	ENTERITIS.	Date Admitted.	24.8.42	Date of Death	10.9.42

Date.	Treatment.	Remarks.
24/8 to 26/8	Admitted with abdominal pain and diarrhoea. Stools averaged 20 a day. B++ M+++ Kaolin given 4 times daily with no improvement. Stools very frequent and patient toxic. Liquids increased. Temp. 102 F. Asp. 5 gr. p.m.	Diet Fluid.
27/8	Saline given for the day.	
28/8	Vomiting commenced, even liquids not retained. Sodi. Bicarb. given.	
29/8 to 31/8	Kaolin stopped - mouth red and tender inside. Saline continued.	
1/9 to 4/9	Stools slightly less - 10 daily - Saline continued - temp 99°p.m.	4/9 Cornflour given.
5/9	Stools increased again. Patient toxic - mouth worse. Corn stopped as unable to swallow. Saline continued.	
6/9 to 8/9	Condition continued getting slightly worse. Temp. 101° p.m.	
9/9	Very toxic and drowsy - recovering to become a little violent and noisy - incontinent - Morphia given ¼ gr.	B Dysentery A Pt Leonard
10/9	Condition worsened overnight - uncontrollable at times. Morphia given to control attacks of shouting and violence. Semicomatose at 5.p.m. Died 6.30.p.m.	

(agd) A.M. Rodrigues, Lieut.
H.K.V.D.C.

CASE NO. 398

No.	13831		Name of Diagnosing Doctor		N.B. Pasary Jemadar, I.MD.
Unit	5/7 R.A.	Nationality	Indian	Rank	Sepoy
				Name	Narotam Singh
Name of Disease	Amoebic Dysentery	Date Admitted	11.6.42	Date Discharged	Died at 1510 hrs. on 10.9.42.

Date	Treatment	Remarks
11.6.42	Complaints: - Fever with rigors, pain in abdomen, loss of appetite, swelling of feet & ankles. Duration: - 40 days. History of Dysentery 4 months ago.. Physical Examination: Patient Anaemic with swelling of feet and ankles. Bronchi in chest. Heart Dilated. ℞ Mist: Pot Cit et Tr Digitalis ℥i T.D.S. Thiamine 1/2 c.c. daily S.C.	
13.6.42	No improvement. Stools: Ova of Ascaeus Lumbericoisles + ℞ Pulv. Santonin one at bedtime. On Round Worm expelled.	
16.6.42	No improvement. ℞ Carb. Tetra chlor et Ol. chenopod. One course given. Five Round worms expelled.	
17.6.42	Mist Ferri et Quin cit . ℥i TDS.	
23.6.42	Stools: E.H. + Patient transferred to Dysentery Ward.	
24.6.42	Emetine Hydrochlor Gr.One Daily.subcutaneously. for 9 days Mist Saline ℥i every Morning. Mist Bismuth ℥i T.D.S.	
4.7.42	No appreciable improvement. Patches of pigment all over skin.	
8.7.42	Mist tonic ℥i B.D. P.C.	
15/7/42	No improvement. Patient c/o frequency of Stools with tenetmus & tormine. Stools: E.H. Nil. Excudate bacillary. Mist Saline ℥i Stat. Followed by ℥ii ending 2 hours for 6 doses. Rice Water AD. Lib.	
16.7.42	Cont. Above Treatment.	
19.7.42	No blood and mucus in stools. Mist. Kaolin ℥i T.D.S.	
25.7.42	Mist Tonic ℥i B.D., P.C. Vit. B_1 Biscuits one B.D.	
10.8.42.	General condition going down day by day. Patient has become bed ridden reduced, as he is, to a skeleton with oedematous feet and ankles. Cont., treatment as above.	

CASE NO.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	Narotam Singh
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
18.8.42	No improvement. Patient passes their offensive stools in bed. Stools - nil abnormal Urine - nil abnormal. Tab. Trianon 4 B.D. for 2 days. Hot Eusol enema one daily. Mist Bismuth ℥i B.D.	
21.8.42	No improvement. Anti-Beri-beri Biscuit One B.D.	
8.9.42	Condition hopeless - Patient passes stools & urine in clothes unconsciously.	
9.9.42	Patient has developed delirium.	
10.9.42	Expired at 3.10 p.M.	

Case No.		Name of Diagnosing Doctor.	C.A. Jackson, Surg. Lieut. R.N.V.R.
Unit	Royal Navy	Nationality. British	Name and Rank. WOPLIN, George Christopher Able Seaman (4243).
Name of Disease.	(i) Pellagra. (ii) Chronic Diarrhoea.	Date Admitted. 23.6.42	Date Discharged. Died 2110 hrs 10.9.42.

Date	Treatment.	Remarks.
23.6.42.	Admitted complaining of (i) Sores on mouth and tongue. (ii) Loss of appetite. (iii) pains in feet. (iv) Occasional diarrhoea.	Bed case. Extra fluids.
25.8.42	Transferred to Verandah ward. A thin emaciated man, with red sore tongue, sordes on both lips, marked pallor. Developed pigmented areas on dorsum of hands and feet. Frequent passage of loose stool. No Blood or mucous. Diffuse obdominal pain.	Kieselguhr t.d.s.
1.8.42	Complains bitterly of painful feet, keeping him awake all night and only relieved by walking about. B.O. x 4 nocte, Loose associated with pains in abdomen Cannot take food well, bread, causes acute nausea. Has to "force" rice down.	Rep. ʁ iii.
25.8.42	Pigmented areas of hands becoming vesiculated and infected - removed blisters and dress acri-flavine.	
30.8.42	Appreciably declining, becoming more dibilitated daily. Bowls open less frequently.	
3.9.42	Very stuperose at times, drowsy in intervals, takes food poorly, general progressive weakness, has vomited last two meals.	
7.9.42	Developed intractable hiccoughs, bringing up bile stained fluid. Incintinent of Faeces - Morphia gr. ¼ nocte .	
9.9.42	Relapsing into coma - sterterous bespirations.	
10.9.42	Died 2110 hrs. Cause of Death (i) Pellagra. (ii) Malnutrition.	

CASE NO. 478

No.	20787		Name of Diagnosing Doctor		Kanta- Singh Jemada- I.M.D.
Unit	5/7 R.n.	Nationality	Indian	Rank	Sepoy
				Name	Chhote Singh (20 yrs).
Name of Disease	Ankylostomiasis	Date Admitted	20.7.42	Date Discharged	Died 11/9/42 at 11 a.m.

Date	Treatment	Remarks
20.7.42	c/o Feve- with -igo- and shive-ing. Indigestion, weakness and giddiness Spleen - palpable. Hea-t & Lungs. No-mal Pyo--hea-+ Anaemia ++ Blood fo- M.P. Negative Stools fo- ova - Negative. Temp 103° F. Duration 12 days.	Weight 28/8/42 - 100lbs
29.7.42	Stools. Ova of Si-cylostomasis	
30.7.42	Feve- Down.	
7.8.42	Feeling Bette-	
13.8.42	Still Weak.	
14.8.42	Blood fo- M.P. Negative Complete Picture (R.B.C. = 1,550,000 (W.B.C. = 4,000 (M.B. = 30% (c.l = 1 Nil abnormal cell (F - 47 L - 51 m - 2	
16.8.42	Feve- 104°F.	
[illegible]	Blood fo- M.P. - Negative. Quinine	
17.8.42	Temp. 104° F.	
18.8.42	Temp. 100	
19.8.42	Temp. 99.6.	
20.8.42	Temp. Normal.	
23.8.42	Temp. 99.4	
24.8.42	Feeling bette-	
27.8.42	Feve- 102° F.	
31.8.42	No feve- fo- the last 3 days. Stools still show ova of Silcylostomasis.	
4.9.42	Feeling bette-	
6.8.42	Slight feve-	
8.8.42	Feve-	
10.9.42	Feve- 102° F. Heart beat i-regula-. 1/cnst-ychnine S.C.	
11.9.42	Condition wo-se since 1 a.m. Breathing laboured & stentorious.	
	Died at 11.a.m.	
11.9.42	Died at 11.am. Kanta- Singh Jem.,I.M.D.	
	Chetan Dev. Jemada- I.M.D. Commanding Dai Ni Bunken Sho.	

Case No.	Name of Diagnosing Doctor.	Surg. Lieut. C.A. Jackson, R.N.V.R.	
Unit R.F.A. Merchant Marine	Nationality. British	Name and Rank.	HUMPHRIES, Joseph. Chief Engineer.
Name of Disease. (i) Chronic Enteritis. (ii) Pellagra.	Date Admitted. 2.9.42	Date Discharged.	Died 8.15.a.m. 11.9.42.

Date	Treatment.	Remarks.
2.9.42	Admitted suffering from extensive ulceration of Pellagranons skin pigmentation of posterior aspect both calves. Past History Severe cardiac beri-beri (wet type) 5 months ago, associated with amoebic dysentery, treated Argyle Street, and St. Theresa's Hospital. Since then intermittent chronic diarrhoea with occasional passage of Blood and Mucous Stool. 2months ago developed Pellagra, of mouth tongue and legs, progressive weakness, loss of appetite and persistent diarrhoea. O.E. Both legs from heel to popliteal space were on their posterior surface, covered with a continuous shallow sloughing ulcer, foul smelling and necrotic. General physical condition very poor, great loss of weight, and impaired cardiac function. (i) Hot fomentation and eusol dressings t.d.s.	(1) Strict bed. (2) Extra fluids. (3) Milk pints 2 daily. (4) Thiamin 1.c.c. 1 M daily.
3.9.42	Very despondent and unable to take food, frequent attacks of nausea and passage of loose motions. Areas of ulceration, spreading with no response to rest.	
5.9.42	Unable to sit up without attacks of syncope, marked cardiac instability and peripheral failure. Takes food poorly.	Milk pints 2. Toast.
6.9.42) 8.9.42)	Gradual deterioration, no signs of healing, sleeping for short interval, very toxic and depressed. Acute cardiac failure this morning -	
9.9.42	responded to Pituitary 1.c.c. and Coramine.	
10.9.42	Cardiac condition poor, signs of sight failure. Chloral Hydrate gr. xxx nocte.	
11.9.42	Another attack ofcardiac failure 7.45.a.m. Poor response to treatment. DIED. 0815. Cause of Death (i) Heart Failure. (ii) Pellagra. (iii) Chronic Enteritis.	

Case No		Name of Diagnosing Doctor		RODRIGUES.A.M.			
Unit	5th A.A. Regiment R.A.	Nationality	English	Name and Rank	MOORES, Henry. Bombardier.		
Name of Disease.	Enteritis & Malnutrition	Date of Admission.	4.9.42	Date of Death	11.9.42		

Date	Treatment	Remarks.
4.9.42	Frequent stools with pain in abdomen 2nd attack within 1 month. Emaciated condition. Nausea and vomiting.	Diet fluid.
5.9.42 to 6.9.42	Saline given. Kaolin attempted but unable to keep same.	6/9. Milk ½ pint daily.
7.9.42	Patient hysterical - 3 fits in the course of the day. Incontinence of faeces.	Cornflour added.
8.9.42	Agitated and semi-conscious. Violent at times attempted suicide twice. Kept quiet with H.I. Morphia.	
9.9.42	Still violent and controlled only by morphia. Temp. 100°F. Pulse 99.	
10.9.42	Quieter with morphia. Stools still diarrhoeaic but controllable.	
11.9.42	Semi-coma and noisy at other times. Respiration and pulse increased. Temp. 102°F p.m. Died 11.45.p.m.	

H.K.V.D.C

Case No.		Name of Diagnosing Doctor	RODRIGUES. A.M.		
Unit	1st Bn. The Middx. Regt.	Nationality.	English	Name and Rank	MAYZES, Eric. Private
Name of Disease	Enteritis	Date Admitted	27.8.42	Date of Death	11.9.42

Date	Treatment	Remarks
27.8.42	Admitted with abdominal pain and diarrhoea with fever. Stools B+-4 M+++. 2nd attack in 2 months.	Diet Liquid
28.8.42 to 31.8.42	Kaolin given 4 times a day - no improvement. Stools still very frequent, over 30 daily. Saline commenced 30.8.42. On serious ill list.	
1.9.42	4 tabs. M & B given with improvement in stools, but general condition very poor. Saline continued. Morphia ¼ gr. at night.	
2.9.42	Kaolin given again.	Fresh milk ½ pint commenced daily.
3.9.42	Treatment same - Intravenous saline given 30.c.c.	
4.9.42	Slightly improved but general appearance poor - bed sores forming on buttock - profuse sweating.	
5.9.42	Continuation of treatment. Stools only about 7 daily.	Cornflour added to diet.
6.9.42 to 9.9.42	Kaolin and Saline treatment continued but to no avail.	
10.9.42	Stools 4 for the day. Patient's general condition very weak. On Dangerously Ill List.	
11.9.42	Very weak - breathing strained - pulse rapid 110. 3.p.m. pulse 130 - respirations 25 - injection Coramine given.	
	Died 5.20.p.m.	

Certified — Lieut
14th Dec 41

CASE NO.

No.	774		Name of Diagnosing Doctor		Major J. Duncan H.K.V.D.C.
Unit	R.C.A.P.C.	Nationality	Canadian	Rank	Sgt. D.W.Lumb.
				Name	
Name of Disease	Acute Bacillary DYSENTERY	Date Admitted	11/9/42	Date Discharged	

Date	Treatment	Remarks
Sept.11	Vomiting - Collapsed. Pule poor 150 . Intravenous Twin Saline & Glucon. ---- by mouth.	Bed - very ill.
12	Incontinent. Stool- mucus. Pulse very poor. Stool Culture B. Dysentery (Some)	
	6.55 pm. Died Heart failure.	
	J. Duncan. Major, H.K.V.D.C.	

Case No.		Name of Diagnosing Doctor	RODRIGUES. A.M.
Unit	H.K.V.D.C.	Nationality. British	No. and Rank PREGNALL, Charles Lance-Corporal.
Name of Disease.	ENTERITIS	Date of Admission 2.9.42	Date of Death 12.9.42

DATE	TREATMENT	REMARKS
2.9.42	Diarrhoea and abdominal pains. Elderly hypertensive type of man.	Diet Fluid.
3.9.42	Kaolin 4 hourly. Aspirin given. Temp. 101·4 Pulse weak.	
4.9.42 to 9.9.42	Saline given daily.and Kaolin. Improvement in Stools but very weak unable to move even to upright position.	Cornflour.
10.9.42	Mag. Sulph. b.d. Stools five for the day. Cough distressing.	
11.9.42	Two stools through the night. Chest heavy and congested but cough productive.	Fresh milk ½ pint.
12.9.42	Chest worse, straining the heart, fingers slightly cyanosed. Trianon given 6 tabs. with Sodi. Bicarb. ½ Morphia given. 10.45.p.m. slight haemoptysis collapse. Coramine H.I. given. Died 11.20.p.m.	

(sgd) A.M. Rodrigues,
Lieut., H.K.V.D.C.

CASE NO.		NAME OF DIAGNOSING DOCTOR.		RODRIGUES A.M.	
UNIT.	MIDDX. REGT.	NATIONALITY.	BRITISH.	NAME & RANK.	Lance-Corporal. TURNER, Ronald.
NAME OF DISEASE	Enteritis	DATE OF ADMISSION.	10.9.42.	DATE OF DEATH.	13.9.42.

DATE.	TREATMENT.	REMARKS.
10.9.42.	Admitted with Diarrhoea and abdominal pain. Stool - Blood x x - Mucus x x. Stools about 15 a day. Mag. Sulph. given 8 grms. for the day.	Fluid Diet.
11.9.42.	Mag. Sulph. repeated. Stools still showing only Blood and Mucus.	
12.9.42.	Kaolin given 4 times. Saline also by mouth - condition poor. Trianon given - 6 in the afternoon . Patient very weak and cold. Morphia given at night.	
13.9.42.	Patient collapsed and cyanosed. Coramine 1.c.c. and strychnine gr. ¼ given at 9.30. a.m. Pulse weak and thready and breathing laboured. Coramine repeated 12.30.p.m. but patient did not recovered. Died 1.p.m.	

(sgd) A.M. Rodrigues,
Lieut., R.K.V.D.C.

Case No.		Name of Diagnosing Doctor	RODRIGUES. A.M.
Unit	Royal Scots	Nationality. British	Name and Rank McCULLUM, Thomas. Private.
Name of Disease.	ENTERITIS	Date of Admission 5.9.42	Date of Death 13.9.42

DATE	TREATMENT	REMARKS
5.9.42	Admitted with Diarrhoea and abdominal pain. Very weak. 3rd bad attack in 3 months.	Fluid Diet
6.9.42 to 9.9.42	Kaolin given daily. Stools about 10 daily. Appetite poor.	
10.9.42	Salts given for the day but no improvement. Condition getting weaker.	Cornflour.
11.9.42	Kaolin repeated with no cessation of stool. Temp. 101° F. Pulse 100. Saline given.	
12.9.42	Repeated saline. Condition collapsed. Coramine given and Morphia.	
13.9.42	Died 12.40a.m.	

(sgd) A.M. Rodrigues,
Lieut., H.K.V.D.C.

Case No.	24		Captain A.H.R. Coombes, R.A.M.C.
Unit	2nd Bn. The Royal Scots	Nationality	British
Name and Rank			GOVAN, Harry. Lance-Corporal.
Name of Disease.	Diphtheria Faucial	Date of Admission	31.8.42
Date of Death			13.9.42 6.50.a.m.

31.8.42	No antitoxin given Gargles Carbolic 1 in 200 2 hourly. Aspirin gr. 10 b.d.	4 days history of sore throat. Membrane over both tonsils extensive.
1.9.42	Gargles. Aspirin gr. 10 nocte.	
2.9.42	Gargles. Fluids only.	
3.9.42	Irrigations Carbolic 1 in 200 2 hourly. Aspirin gr. 10 nocte.	Very heavy infection
5.9.42	Antitoxin 10,000 units (M) given. Aspirin gr. 10 6.p.m. Irrigations continued.	Reaction to antitoxin - Headache and fever 48 hours.
6.9.42	Aspirin gr. 10 b.d. Gargles.	Much improved.
7.9.42	C.T.	Better.
8.9.42 - 9.9.42	C.T.	Great improvement in throat.
11.9.42	Tab. Colocy. Co. i. 8.p.m.	Throat clear. Very weak Anaemia +.
12.9.42	Gargles. Full Diet.	Does not help himself.
13.9.42	Died 6.50.a.m.	Cardiac collapse. Death.

CASE NO. 703 (Gun Club Hill)

No.	5317		Name of Diagnosing Doctor		Kartar Singh Jemadar, I.M.D.
Unit	H.K.S.R.A.	Nationality	Indian	Rank	Gunner
				Name	Abdul Rehman Age:25.
Name of Disease	Jaundice Haemolytic	Date Admitted	12.9.42.	Date Discharged	Died 14.9.42. at 12.40 p.m.

Date	Treatment	Remarks
12.9.42	Fever and piles, weakness and yellow vission -- Duration: 2½ months No bleeding now. Heart. Irregular, fast and sound indistinct. Lungs. No abnormality. The patient is very serious anaemic. apparently air hunger. Jaundice + +	
13.9.42	Condition getting worse hour by hour.	
14.9.42	Condition very grave since 8.A.M. Died at 12.40 P.M. Kartar Singh Jem. I.M.D.	

Chetav Dev.

Jemadar, I.M.D.,
Commanding Dai Ni Bunken Sho.

Case No		Name of Diagnosing Doctor		RODRIGUES.A.M.		
Unit	Merchant Service	Nationality	Irish	Name and Rank	FREW, George. Captain	
Nature of Disease	Enteritis and Chronic Rheumatism.	Date Admitted	11.9.42	Date Discharged	Died 14.9.42	

DATE	TREATMENT	REMARKS
11.9.42	Admitted with diarrhoea and passage of large quantity of blood in stools. Had Chronic Rheumatism previous to this attack, and still suffering from same. Stools watery and at times uncontrollable. Ol. Ricini given ½ oz. on admission.	Fresh milk ½ pint and cornflour.
12.9.42	Appearance brighter. 6 stools for the night. Kaolin given 4 times. Chloral Hydrate 5 gr. given at night.	
13.9.42	Weak condition. Pulse 100 low tension. H.I. Strychnine gr. 1/60th - Adrenalin ~~½cc~~ Slight heart attack in the afternoon lasting ½ hour. Morphia ¼ gr. at bedtime.	
14.9.42	Bismuthgiven for the day. Condition very much weaker. Refused milk and semicomatose in the afternoon. Heart attack at 4.p.m. 1/60th gr. Strychnine given with some relief but coma developed at 6.p.m. with shallow respirations and weak rapid pulse. Died 7.20.p.m. (sgd) A.M. Rodrigues, Lieut., H.K.V.D.C.	

Capt Frew
Typhoid

Rodrigues

Case No		Name of Diagnosing Doctor		Surg. Lieut. C.A. Jackson, R.N.V.R.	
Unit	R.A.M.C.	Nationality	British	Name and Rank	TERRAN, Charles, Q.M.S. (W.O.11).
Name of Disease	Typhoid Fever.	Date Admitted	30.8.42	Date Discharged	Died 9.15 p.m. ~~15.9.42~~

DATE	TREATMENT	REMARKS
30.8.42	Collapsed on parade, diarrhoea two days. O.E. Very dehydrated, semi-conscious. tongue dry and rough, hollow cheeks, bright eyes, flushed. Recent loss of weight + + Chest Abdomen Scapheid, pigmented spots + + T. 103. P. 110/min. Stool -loose, faeculent.	Fluids + + Saline oz. 1 to pint t.d.s. Milk 1 pint daily.
2.9.42	Slight improvement - taking fluids well. Transferred to Dyssentery Wards for convenience of nursing.	Cornflour daily.
3.9.42	I.S.Q. Maintaining temperature, pulse slow. Differential blood count - shows no indication of leucopaemia. Developing signs of basal bronchitis.	
5.9.42	Some respiratory distress, frequent passage of loose faeculent steels. Appearance consistent with Typhoid state.	
13.9.42	Improvement not maintained - chest involvement increasing. Morphia gr. ¼ Nocte.	
14.9.42	Very dyspnaeic - ~~xxxxx~~ worse in Fowler's position. Taking fluids well.	
15.9.42	More toxic. 6.30 p.m. passed 4 ounces of pure blood p.r. 7.10.p.m. - passed about 1 pint p.r. Condition deteriorating.	

Died 9.15 p.m.

Cjackson

(sgd) C.A. Jackson, Surg. Lieut. R.N.V.R.

CASE NO. 410

No.	18063		Name of Diagnosing Doctor		N.B. Pasary, Jem. I.M.D.
Unit	I. H. C.	Nationality	Indian	Rank	Sevoy
				Name	Phinjoo Lama
Name of Disease	Tuberculosis (Lungs)	Date Admitted	1816.42	Date Discharged	Died on 15.9.42. at 3 A.M.

Date	Treatment	Remarks
18.6.42	Complaints of pain in the suprapubic region, loss of appetite and evening rise of temperature. Duration - three weeks. Spleen - not palpable. Tenderness over suprapubic region + + General emaciation + +	
20.6.42	Blood for M.P. - B.T. rings ++	
30.6.42	Sputum for T.b. + +	
4.7.42	Eyes. Congested and water coming out from the eyes.	
15.7.42	Cough. & expectoration + + Pain in the suprapubic region less.	
25.7.42	Loss of weight + +	
	Urine for exam: Sugar - } Albumin - } Nil Phosphate - } Cast- } Reaction - Acid.	
30.7.42	No improvement. Patient is reduced to a skelton.	
13.8.42	Patient is more emaciated.	
15.9.42	Patient expired at 3.a.m.	

N.B. Pasary.

Jem. I.M.D.

Chetan Dev.

Jemadar, I.M.D.
Commanding Dai Ni Bunken Sho.

Case No	1	Name of Diagnosing Doctor	Rodrigues A.M.		
Unit	Corps of Military Police.	Nationality	British.	Name and Rank	Lance Corporal WRIGHT, Charles.
Name of Disease	Enteritis and Post-Diphtheritic Myocarditis.	Date Admitted	8.9.42.	Date Discharged	15.9.42.

DATE	TREATMENT	REMARKS
8/9/42.	Patient had Diphtheria about 2 months ago. Recovered without serum at St. Theresa's Hospital and returned to Shamshuipo to the Convalescent Ward. He developed a partial paletal palsy causing regurgitation through the nose on drinking water. Pulse was then 72 and regular. He developed Diarrhoea with passage of Mucus and Blood in stools. Stools very frequent and patient very restless. Ol. Ricini given on admission.	Diet - Fluid and Cornflour.
9/9/42.	Kaolin given 4 times per day. Patient taking very little fluid. Complained of palpitation.	
10/9/42. and 11/9/42.	Mag. Sulph. twice for the day. Stools lessened to 6 daily - still Blood present.	
12/9/42.	Kaolin given but later in day stools increased. Trianon given 6 Tablets.	
13/9/42.	Trianon continued. Patient very restless, moving about a lot. Pulse a 100 and patient sweating a lot. Chloral Hydrate given at bedtime (5 gr. dose).	
14/9/42.	Stools improved considerably - none in the early morning nor the rest of the day. Patient still moving about a lot and sometimes rambling in speech. Pulse upset and heart sounds accentuated. Chloral Hydrate 5 grs. at bedtime.	
15/9/42.	Cyanosed in extremities and cold. Coramine 1 c.c. given at 10 a.m. but with no improvement. DIED 2.30. p.m.	

(A.M. Rodrigues).
Lieut., H.K.V.D.C.

Dispensary copy
Dr Mills

Rodrigues

Case No		Name of Diagnosing Doctor	Captain R.L. Lancaster, R.A.M.C.		
Unit	Merchant Service	Nationality	British	Name and Rank	WARE, John. Chief Engineer.
Name of Disease	Malnutrition.	Date Admitted	20.8.42	Date Discharged	Died 8.45.a.m. 16.9.42

DATE	TREATMENT	REMARKS
20.8.42	Full Diet. Fresh Milk. Yeast. Carbolic Mouth Washes.	Sore mouth. Dermatitis of Scrotum. Membraneus exudate in lips. Lachymation.
21.8.42	Membraneus exudate right side of tongue.	
22.8.42	Exudate readily detachable.	
23.8.42	Membrane extending over left cheek.	5% Phenol in veg.oil.
24.8.42	Expecteration of salty phlegm.	
25.8.42	Membrane receding.	
27.8.42	Typical Pellagra tongue.	
2.9.42	Increasing weakness. Pulse 110.	
4.9.42	Cramps in feet. Pulse 102 irregular.	
7.9.42		Inj. Digitalin gr.1/100
8.9.42		" " " "
9.9.42		" " " "
10.9.42	Flatulent.	Mist. Sodii Bicarb.
15.9.42	Temp. 103.	Inj. Digitalin 1/100th.
16.9.42	Died 8.45.a.m.	

(sgd) R.L. Lancaster, Capt., R.A.M.C.

Case No		Name of Diagnosing Doctor	RODRIGUES. A.M.		
Unit	1st Bn. The Middlesex Regiment.	Nationality	British	Name and Rank	CROWE, Joseph G. Lance-Corporal
Name of Disease	Enteritis and Malnutrition	Date Admitted	6.9.42	Date Discharged	Died 6.25.a.m. 18.9.42

DATE	TREATMENT	REMARKS
6.9.42	Admitted from Main Ward with diarrhoea and passage of blood and mucous in stools. 3rd Attack. Has had painful feet for 2 months. Very thin and emaciated.	Diet - Fluids.
6.9.42 to 10.9.42	Kaolin given 4 times daily but stools showed no improvement. Still about 20 daily. Some vomiting controlled by Sod. Bicarb. gr. 10.	10/9. Cornflour added to diet.
11.9.42	Lag. Sulph. ℥ii given twice in the day.	
12.9.42	Bism. Subnit. gr. 5 b.d.	12.9. ½ pint milk added to diet.
13.9.42 to 14.9.42	Kaolin repeated but with no marked improvement. Temp. 101 p.m.	
16.9.42 to 17.9.42	Bismuth repeated - stools a little less frequent. About 6 for the day. Patient taking very little food.	
18.9.42	4.a.m. Sudden change for the worse - respiration strained and pulse rapid and weak.	
	Died 6.25.a.m.	
	(sgd) A.M. Rodrigues, Lieut., H.K.V.D.C.	

Deputy Inhalt Officer
Hyl Crowe

Case No.		Name of Diagnosing Doctor		RODRIGUES A.L.		
Unit	1st Bn. The Middx. Regt.	Nationality	British	Name and Rank	[illegible] T, Daniel. Private	
Name of Disease	Enteritis and Malnutrition	Date Admitted	15.9.42	Date Death Discharged	18.9.42	

DATE	TREATMENT	REMARKS
15.9.42	Patient admitted with diarrhoea and passage of blood and mucous in stools. About 8 stools daily Previous history of 4 attacks of dysentery. Bed-ridden since June and suffering from dry Beri Beri and general malnutrition. Patient very emaciated and weak. Heart action poor. Ankles and front of feet swollen.	Diet - Fluids and Milk 2 pint daily.
16.9.42 and 17.9.42	Bismuth given b.d. Slight improvement in stools both in frequency and quality. Slightly delirious at nights. Morphia given.	Beri-beri. Dysentery. P.U.O. Enteritis
18.9.42	Patient semi-conscious with incontinence of stools and urine. Inj. Coramine 1.c.c. given - no improvement. Quiet at night.	
19.9.42	Condition worse. Unconscious - pulse weak. Died 10.55.a.m. (sgd) A.L. Rodrigues, Lieut., H.K.V.D.C.	

Case No		Name of Diagnosing Doctor		Major L.F. BROWN, R.A.M.C.	
Unit	2nd Bn. The Royal Scots.	Nationality	British	Name and Rank	TOIST, James Lance-Cpl.
Name of Disease	Diphtheria.	Date Admitted	4.9.42	Date Discharged	Died 23.9.42 0515 hrs.

DATE	TREATMENT	REMARKS
4.9.42	Admitted to acute Diphtheria Ward. No serum available. Carbolic Acid Gargles.	Pauciel and Laryngeal Diphtheria. Throat gradually cleared with the treatment available. P.104
18.9.4	Transferred to Convalescent Ward. Lying Flat.	P.96. Some palatal & laryngeal palsy. Palsies & velopin.
25.9.42	Lying Flat.	P.104. Some cough with sputum. Cough ineffectual owing to laryngeal palsy. Fluids return down nose.
28.9.42	" "	P.88 on waking. 100 at 11.a.m. c/o nausea BO.
6.9.4	" "	P.108. Cough troublesome with mucopurulent sputum which is hard to bring up. A few moist sounds heard at right base.
13.9.4	" "	Sputum easier to raise when sitting up. He is now apt to have severe coughing fits when taking fluids.
15.9.42	" "	Much loose sputum in throat. Chest: Many moist sounds at both bases with impairment of P.N. Two attacks of breatlessness in day both relieved by Inj. Atropine gr. 1/50. Breathing very shallow and entirely costal.
18.9.42	" "	is difficult. After respiration still
1.9.42	Propped up in bed with backrest. Inj. Atropine 1/50 gr. 2100 hrs.	t: still marked
22.9.42	Propped up. Inj. Atropine gr. 1/50 0930 hrs. " " " " } 2:00 hrs. Inj. Coramine 1.7.c.c. }	ounds heard at ot working at all.
2 .9.4	(continued). Between attacks of Dyspnoea breathing the second attack although improved by Atropine, re difficult. Finds much difficulty in talking. Che impairment of Percussion Notes. Many coarse moist both bases. Respiration very shallow. Diaphragm Great distress.	
23.9.42	Inj. Coramine 1.7.c.c. 0345 hrs.	
	Died 0515 hrs.	
	Cause of Death (i) Broncho-Pneumonia. (ii) Diaphragmatic Paralysis.	
	(Sgd). K.F. Brown, Major, R.A.M.C.	

Case No		Name of Diagnosing Doctor	R.L. LA CASTER		
Unit	Royal Navy	Nationality	British	Name and Rank	CASWELL, Charles Alfred Leading Seaman.
Name of Disease	Influenza.	Date Admitted	9.9.42	Date Died ~~Discharged~~	22.9.42 2.15.a.m.

DATE	TREATMENT	REMARKS
9.9.42	Diet. No Rice or Yeast. Cornflour - Milk.	Intermittent diarrhoea for 9 months. Dermatitis of shins
15.9.42	Kieselghur quat 1 die. Aspirin b.d.m.	Pain and stiffness in neck. Cannot raise right arm. Diarrhoea: Motions 5 3
17.9.42		Vomiting bile.
20.9.42	Inj. Morphine Tart. grs. ¼. Left lower limb elevated.	Left Lower Limb:- Passive Oedema Pain in right iliac fossa. General condition very poor.
21.9.42	Inj. Morphine Tart. gr ¼.	Condition grave
22.9.42	2.15.a.m. Died.	

(sgd) R.L. Lancaster,
Captain, R.A.M.C.

Caswell L/S RN.
Pellagra.

CASE NO.		NAME OF DIAGNOSING DOCTOR		Rodrigues. A. M.			
UNIT	R. E.	NATIONALITY	British	NAME AND RANK.	L/Cpl. Stewart James.		
NAME OF DISEASE	I. Chronic Enteritis II. Malnutrition.			DATE ADMITTED	4.9.42.	DATE DISCHARGED	23.9.42.(Dead)

DATE.	TREATMENT	REMARKS.
4.9.42.	Admitted with abdominal pain and diarhoea. Stools.Bl.++ M.+++ Had 2 attacks of dysentery previously.	Diet. Liquid.
5.9.42.	Kaolin 4 times daily	½ pint Milk added to diet.
6.9.42 to 9.9.42.	Kaolin cont'd. Stools improved in frequently and quality becoming only diarrhoeic - but patient very dehydrated and emaciated.	
10.9.42. to 15.9.42.	Bismuth given twice daily. Stools lessened to 2 daily.	Placed on full diet plus milk.
15.9.42 to 20.9.42.	Stools settled in frequenty , but general condition very weak. Pulse weak and rapid 100. Mouth raw and painful. Unable to swallow properly.	Corn, flour added to diet.
21.9.42.	Some nausea. Sod.Bic. gr.V.b.d.	
22.9.42.	Condition deteriorated - heartweaken in action. Difficulty in breathing and restlessness. Coramine given.	
23.9.42.	3 a.m. Pulse 120 - respiration 30. Died 4.10 a.m.	Malnutrition Dysentery. Lt Col Stewart.

A. M. Rodrigues.

Rodrigues

Case No		Name of Diagnosing Doctor	R.L. LANCASTER.		
Unit	1st Bn. The Middx. Regiment	Nationality	British	Name and Rank	JENNINGS, Ernest Private
Name of Disease	MALNUTRITION.	Date Admitted	20.6.42	Date Died ~~Discharged~~	24.9.42 12.15.a.m.

DATE	TREATMENT	REMARKS
20.6.42	Thiamin injections on alternate days.	Wasting. Debility. Beri Beri. Oedema of legs.
28.7.42	Transferred to St. Teresa's Hospital.	
6.8.42	Returned to S.P.W. Camp Hospital.	
14.9.42	Diet : Milk - Cornflour.	
15.9.42		Intermittent Diarrhoea.
20.9.42	Body shaved.	Pediculosis.
24.9.42	Died at 12.15.a.m.	

(sgd) R.L. Lancaster,
Capt., R.A.M.C.

CASE NO. 9

No.	830		Name of Diagnosing Doctor		Major. G.F.Harrison.
Unit	R. C. C. S.	Nationality	Canadian	Rank	L/Sergeant
				Name	WHITE. W. J.
Name of Disease	1. Diphtheria 2. Heart Failure.	Date Admitted	22/9/42.	Date ~~Discharged~~ Death	25/9/42.

Date	Treatment	Remarks
22/9/42	Admitted at 10.00 A.M. Diagnosis -- Diphtheria -- Heart Failure. Admitted complaining of sore throat for about six days. Sore mouth for three months. Burning feet for three months. Diarrhoea for 8 days. Patient's Past History -- Dysentery January for 12 days. Dysentery - March for 7 weeks. Dysentery four or five times since then. History Present Illness -- Sore mouth off & on for three months. Never really clear. Stabbing pains in feet, especially at night. Throats has not been very painful least three days. Feet are very tender. On Examination -- Large thick, white membrance over left tonsil & on posterior wall of pharynx. Markes angular stomatitis present. Neck swollen on both sides with diffuse, brawny, oedematous, glandular swellings, which are very tender. Heart sounds are normal. Pulse rate slow & strong. Lungs, clear. Central nervous System -- Knee & ankle reflexes present & equal. Plantar responses flexor. Labaratory Report on Throat Swab:. " No Vincents Organisms present". Diphtheroids present, some of which resemble Klebs Loefflers Bacilli. Urine Test for Albumen -- Negative. Treatment: 10 mgm Thiamin Chloride subcutaneously & 30 mgms intravenously. Hot irrigations to throat. Antiphlogistine to neck. Sulphathiazole 6.0 grams. Sugar drinks + + + . All extras, including plenty milk.	Stretcher.
23/9/42	No Sleep. Can scarely talk. Complains of difficulty in breathing. On Examination: Neck is much more swollen. Heart sounds are normal. Treatment: Repeat as before. Blood transfusion of 540 ccs of citrated blood from Pte.Milord (a convalescent diphtheria case).	
24/9/42.	Says feel slightly better. Slept well. Throat & neck as before. Treatment: Hot irrigations. ice packs to neck. 10.mgm Thiamin Chloride every day. Sulphathizole 4.0.grams.	
25/9/42 Morning	Says he "feels awful". Head feels as if it were bursting. Throat feels worse. Treatment: Repeat the same. Glucose 50% - 20 ccs given intravenously.	
7.45.PM.	Appeared normal, i e. same as morning. No difficulty with breathing; pulse rate conly 100.	
7.50.PM.	Suddenly,the Orderly noticed him shaking his head to indicate that he could not breathe. Tongue was pulled out. End of bed raised. He became rapidly very cyanosed. I happened to be outside the Ward & attended to him immediately, performing an immediate laryngotomy. A tube was inserted, & a free airway assured.	

CASE NO. [redacted] Continuation: L/Sgt. WHIT[redacted]. W. J.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
	patient took a few more bresths, by the aid of artifical respiration but the heart slowed & finally stopped, & the Patient died at 8.00.p.m. Results of Post Mortem Examination on the body of the late Lance Sergeant White, W.J. Greyish-white membrance on left tonsil. Trachea: Clean. No membrance visible. Lungs: Normal. Heart: Right side rather dilated. Otherwise nothing abnormal seen. Spleen: Normal size but extremely sofe. Liver: Normal. Kidneys: Normal. Conclusion: The Patient died from Diphtheria & Heart Failure. Signed: G.F.Harrison. Major: R.A.M.C.	

CASE No		NAME	Rodrigues, A. V.
UNIT. W.E.V.D.C.		British.	NAME AND RANK. L/Cpl. Wickman, John.
DIAGNOSIS.	Acute Enteritis.	DATE ADMITTED.	19/9/42
		DATE DISCHARGED.	Died 26/9/42.

DATE.	TREATMENT.	REMARKS.
19/9/42	Admitted with diarrhoea and passage of blood and mucous in stool. Very drowsy and toxic. Dehydrated. M.Sulph.given in the morning on admission and saline by mouth. Temp.100. Pulse 90. Injection of Trianon 4.cc given in the evening. Placed on S.I.List.	...ot fluid. Rodrigues
20/9/42	Still semi-comatose - 2 cc Trianon given by injection.	
21/9/42	Slightly improved - no stools for the night. Temp 97. Pulse 90. 3 Trianon given and plenty of fluid taken.	
22/9/42	2.cc Trianon injected in the morning. Temp:100. Pulse 100. Patient's mind still not quite clear - restless. Morphia 1/4gr. at bedtime.	Dysentery 1/42 Wickman
23/9/42 24/9/42	Fluid pushed freely. Some cornflour given. Stools no longer showing blood.	
25/9/42	Diarrhoeic stool incontrollable. Bismuth Sulnit ... gr. V + ∞. Pulse full but increased in rate 108. Temp:100.8F. Quite at night.	
26/9/42	Breathing heavy at 4.am. and Strained Inj.Strychn. 1/60. given but condition deteriorated quickly. Died 6.15.A.M.	

Sgd: Rodrigues, A. V.
W.E.V.D.C.

Case No		Name of Diagnosing Doctor		RODRIGUES. A.L.			
Unit	H.E.V.D.C.	Nationality	British	Name and Rank	MICKAN, John Lance-Corporal		
Name of Disease	Acute enteritis.		Date Admitted	19.9.42	Date Died ~~Discharged~~	26.9.42 6.15.a.m.	

DATE	TREATMENT	REMARKS
19.9.42	Admitted with Diarrhoea and passage of Blood and Mucous in Stools. Very drowsy and toxic. Dehydrated. Liq. Sulph given in the morning on admission and saline by mouth. T.100. P.90. Injection of Trianon 1.c.c. given in the evening. Placed on S.I. List.	Diet - Fluids.
20.9.42	Still semi-comatose. 2.c.c. Trianon given by injection.	
21.9.42	Slightly improved.- no stools for the night. T.97. P.90. 3 Trianon given and plenty of fluids taken.	
22.9.42	2 c.c. Trianon injected in the morning. T.100 P.100. Patient's mind still not quite clear - restless - Morphia ¼ gr. at bed-time.	
23.9.42) 24.9.42)	Fluids pushed freely - some cornflour given - stools no longer showing blood.	
25.9.42	Diarrhoea stool uncontrollable - Bismuth Subnit. gr. 5 t.d.s. Pulse full but increased in rate 108. Temp. 100.8 F. Quiet at night.	
26.9.42	Breathing heavy at 4.a.m. and strained. Strychnine gr. 1/60 given but condition deteriorated quickly.	
	Died 6.15.a.m.	

(sgd) A.L. Rodrigues,
Lieut., H.E.V.D.C.

Case No		Name of Diagnosing Doctor	R.L. LANCASTER.		
Unit	Royal Air Force	Nationality	British	Name and Rank	[illegible], Stanley Alfred Leading Aircraftman
Name of Disease	D[illegible].	Date Admitted	24.8.42	Date Died / Discharged	25.8.42 11.30.am.

DATE	TREATMENT	REMARKS
24.8.42	Rest in bed.	Sore throat. Weakness in legs. General spasticity. Reflexes all incd. Babinski's sign positive.
1.8.42	Inj. iii Typhoid vaccine.	
3.8.42	T.100.	
4.8.42	10 c.cs Lvipan. Lumber puncture.	More helpless and demented than before. Complete loss of spasticity after 3 c.cs injection. CSF: Clear and und[illegible] moderate pressure. P.105.
5.8.42		
11.8.42		T.100. Various wounds and abrasions ankle and elbo[illegible], sacral region. Incontinence of urine and faces. General condition deteriorating.
20.8.42		
25.8.42	Death 11.30.a.m.	

(sgd) R.L. Lancaster,
Capt., R.A.M.C.

CASE NO.

No.	783.		Name of Diagnosing Doctor		Major.G.F.Harrison. R.A.M.C.
Unit	R. C.	Nationality	Canadian.	Rank	Private.
				Name	E. Pastuck.
Name of Disease	1.Diphtheria. 2.Internal Haemorrhage. 3.Heart Failure.	Date Admitted	12.9.42.	Date Discharged	Died. 26.9.42.

Date	Treatment	Remarks
12.9.42.	Diagnosis: 1. Diphtheria. 2. Internal Haemorrhage. 3. Heart Failure. Complains of : Sore throat for 1 week. Patient's Past History: Burning pains in the legs for 1 month. Sore mouth for 2 months. Dysentery in April,1942 for 6 weeks. History of Present Illness: Sore mouth & sore tongue for 2 months. Sore throat for 1 week. Headache. His eyes smart, when he goes into the sun. On Examination: There is a small, white membrane on the right tonsil. The neck glands on each side are rather enlarged. Tongue is smooth, shiny & red. Heart sounds are strong & normal. Central Nervous System - knee reflexes present & equal. Ankle reflexes are both diminished. Vibration sense is normal in the legs. No calf tenderness. Treatment: Hot irrigations to throat. Chlorin Chloride 10 mms. Labaratory report on throat swab: No Klebs Loefflers Bacilli. Scanty Vincent's organisms present.	
13.9.42.	Feels " not too bad." General condition very much as before. R.H. has septic right index finger(? same infection as throat; i.e. cutaneous diphtheria). Treatment: As before. Also wet sulphat dressing to right finger.	
14.9.42.	Membrane on right tonsil is much larger today. Heart sounds are normal. Treatment: Candle's paint, & hot irrigations.	
15.9.42.	Did not sleep well. Throat is painful. On Examination: The membrane has increased in size & has spread to the uvula, which is much swollen. There is also some annular stomatities. A bloody, purulent discharge comes from each nostril (he has had this for 2 days.) Heart sounds are normal. Treatment: Stop Candle's paint. Repeat hot irrigations. Anti-Diphtheristine to neck. Sulphathiazole 6.0 grms stat. day. Laboratory Report on throat swab: No Klebs Loefflers Bacilli or Vincent's organisms found.	
16.9.42.	Throat seems better. Heart sounds are slow & strong. Treatment: To have 10 cems Chlorin Chloride per day. Sulphathiazole 4.0 grms today.	
17.9.42.	No change. Laboratory Report on urine. No albumen present. Treatment: As before. Sulphathiazole 4.0 grms today.	

CASE NO.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
19.9.42.	Throat is still very sore. Heart rate is becoming more rapid. Treatment: Sulphathiazole 3.0 grms today.	
19.9.42.	No change. Stop Sulphathiazole.	
20.9.42.	There has been much bleeding from the mouth & nose for the last two nights. On examination: Mouth & nose are full of blood clots. Tonsils are both exacerated. Treatment: Mouth washes only.	
22.9.42.	There is a large, raw area around the anus. (There is no diarrhoea). Treatment: Add. - Multivit. capsules 2 per day. Ointment to anus. On examination: Heart sounds are normal. Blood pressure 110/80 Capillary Resistance Test - Negative.	
23.9.42.	Does not feel so well. Headache all yesterday. Has had much bleeding from the nose, which is still bleeding slightly. There is evidence of haemorrhage in the skin of the left eyelid. Pulse rate strong & slow. Treatment: Ice to nose.	
24.9.42.	Nose bleeding continues at intervals, but he says he feels all right.	
25.9.42.	Nose bleeding all last night. Vomiting of some greenish fluid. Treatment. Continue gentle mouth washes. Add ascoroic acid tablets 2 per day.	
26.9.42.	The haemorrhage over the left eye is darker & larger than it was. The nose & throat still tend to bleed. Vomited at 8.30 A.M. a large amount of greenish fluid. Right neck is now rather swollen. Nose & mouth are full of clotted blood. Treatment: Glacium gluconate intravenously - slowly given.	
11.30 A.M.	General condition critical. Is pulseless & pale. There are haemorrhages under the skin of the right arm. The index finger of the right hand is dark & it is evident that there has been bleeding into the skin around the sore. Heart sounds are much more rapid than they were this morning.	
11.45. A.M.	Patient gave a series of gasping respirations & his heart stopped. The patient died.	

CASE NO. Contd. No.2.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
	Results of the Post Mortem Examination on the Body of the Late Private L. Tastuck.	
	There were haemorrhages in the skin of the left eyelid & of the right arm on its external aspect.	
	Trachea. No membrane present. Just above the vocal chords there was a mass of blood-stained necrotic tissue, which formed part of the wall of the trachea (it was not detachable, & therefore, presumably was not old blood clot.)	
	Lungs. The anterior surface of the both lungs showed well-marked sub-pleural haemorrhages. On sectioning the lungs both were widely studded with large haemorrhages, which were more marked in the right than in the left lung.	
	Pericardium. No excess of fluid.	
	Heart. Right side rather dilated, muscle rather flabby. Valves normal.	
	Liver. Normal.	
	Gall Bladder. Enlarged, hard & red.	
	Spleen. Slightly enlarged. Firm. Weight 5½ ozs.	
	Kidneys. Normal.	
	Conclusion. It is evident from the history of pain in the legs, sore mouth & sore tongue & from the appearance of the tongue, which was smooth & shiny & deep red, & also the angular stomatitis, that this patient was suffering from Avitaminosis B. He died from the effect of Diphtheria; that is to say, Heart Failure & the haemorrhages, which were the result of the intense toxaemia.	
	G. T. Harrison. Major. R.A.M.C. Medical Specialist.	

CASE NO.

No.	783		Name of Diagnosing Doctor		Major (R.A.M.C.) C. F. Harrison.
Unit	W. G.	Nationality	Candian.	Rank	Private.
				Name	N. Eastuck.
Name of Disease	1. Diphtheria. 2. Internal Haemorrhage. 3. Heart Failure.	Date Admitted	12.9.42.	Date Discharged	Died 26.9.42.

Date	Treatment	Remarks
12.9.42	Diagnosis ; 1. Diphtheria. 2. Internal Haemorrhage. 3. Heart Failure. Complains of : Sore throat for 1 week. Patient's Past History : Burning pains in the legs for 1 month. Sore throat for 2 months. Dysentery in April 1942, for 6 weeks. History of Present Illness:- Sore mouth & Sore Tongue for 2 months. Sore throat for 1 week. Headache. His eyes smart, when he goes into the sun. On Examination:- There is a small, white membrane on the right tonsil. The neck glands on each side are rather enlarged. Tongue is smooth, shiny & red. Heart sounds are strong & normal. Central Nervous System Knee reflexes present & equal. Ankle reflexes are both diminished. Vibration sense is normal in the legs. No calf tenderness. Treatment :- Hot irrigations to throat. Thiamin Chloride 10 mgms. Laboratory Report on Throat Swab :- No klebs Loefflers Bacilli. Scanty Vincent's organisms present.	
13.9.42.	Feels "not too bad". General condition very much as before. N.B. Has septic right index finger (? same infection as throat; i.e. cutaneous diptheria.) Treatment:- As before. Also, mag. sulphate dressing to right finger	
14.9.42.	Membrane on right tonsil is much larger to-day. Heart sounds are normal. Treatment :- Mandle's paint, & hot irrigations.	
15.9.42	Did not sleep well. Throat is painful. On examination:- The membrane has increased in size & has spread to the uvula, which is much swollen. There is also sore angular stomatitis. A bloody, purulent discharge comes from each nostril (he has had this for two days). Heart sounds are normal. Treatment:- Stop Mandle's Paint. Repeat hot irrigations. Anti-Phlogistine to neck. Sulphatiazole 4.0 grams per day. Laboratory Report on Throat Swab : No klebs Loefflers Bacille or Vincent's organisms found.	
16.9.42.	Throat seems better. Heart sounds are slow & strong. Treatment: Is having 10 mgm Thiamin Chloride per day. Sulphathiazole 4.0 grams to-day.	
17.9.42.	No change. Laboratory Report on Urine: No Albumen present. Treatment:- As before. Sulphathiazole 3.0 grams to-day.	
18.9.42	Throat is still very sore. Heart rate is becoming more rapid. Treatment:- Sulphathiazole 3.0 grams to-day.	
19.9.42.	No change. Stop Sulphathizole.	
21.9.42.	There has been much bleeding from the mouth & nose for the last two nights.	

CASE NO. SHEET NO.....II. (Pte. N Pastuck.)

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
	On Examination:- Mouth & nose are full of blood clots. Knee jerks are both exaggerated. Treatment:- Mouth washes only.	
22.9.42.	There is a large, raw area around the anus.(There is no diarrhoea.) Treatment:- Add. Multi-vit capsules 2 per day. Ointment to anus. On examination:- Heart sounds are normal. Blood Pressure 110/80. Capillary Resistance Test - Negative.	
23.9.42.	Does not feel so well. Headache all yesterday. Has had much bleeding from the nose, which is still bleeding slightly. There is evidence of haemorrhage in the skin of the left eyelid. Pulse rate strong & slow. Treatment:- Ice to nose.	
24.9.42.	Nose bleeding continues at intervals, but he says he feels all right.	
25.9.42.	Nose bleeding all last night. Vomiting of some greenish fluid. Treatment:- Continue gentle mouth washes. Add ascorbic acid tablets 2 per day.	
26.9.42.	The haemorrhage over the left eye is darker & larger than it was. The nose & throat still tend to bleed. Vomited at 8.30 A.M. a large amount of greenish fluid. Right neck is now rather swollen. Nose & mouth are full of clotted blood. Treatment:- Calcium gluconate intravenously - slowly given.	
11.30. A.M.	General condition critical. Is pulseless & pale. There are haemorrhages under the skin of the right arm. The index finger of the right hand is dark & it is evident that there has been bleeding into the skin around the sore. Heart sounds are much more rapid than they were this morning.	
11.45. A.M.	Patient gave a series of gasping respirations & his heart stopped. The patient died.	

****

CASE NO. SHEET NO. .....III. (Pte. N. Pastuck.)

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks

R E S U L T S.

Of the Post Mortem Examination on the body of the Late Pte.N.Pastuck.

There were haemorrhages in the skin of the left eyelid & of the right arm on its external aspect.

Trachea : - No membrane present. Just above the vocal chords there was a mass of blood-stained necrotic tissue, which formed part of the wall of the trachea (it was not detachable, & therefore, presumably was not old blood clot.)

Lungs:- The anterior surface of both lungs showed well-marked sun-pleural haemorrhages. On sectioning the lungs both were widely studded with large haemorrhages, which were more marked in the right thanin the left lung.

Perciardium:- No excess of fluid.

Heart:- Right slide rather delated. Muscle rather flabby. Valves normal.

Liver:- Normal.

Gall Bladder: Enlarged, hard & red.

Spleen:- Slighly enlarged. Firm. Weight 5½ozs.

Kidneys:- Normal.

Conclusion:- It is evident from the history of pains in the legs, sore mouth & sore tongue & from the appearance of the tongue which was smooth & shiny & deep red, & also from the angular stomatitis, that this Patient was suffering from Avitaminosis B. He died from the effect of Diphtheria, that is to say Heart Failure & the Haemorrhages, which were the result of the intense toxaemia.

G. F. Harrison.
Major - R. A. M. C.
Medical Specialist.

Case No		Name of Diagnosing Doctor		Dr. S.L. Bard.		
Unit	Royal Navy	Nationality	British	Name and Rank	Sobbe. W. Petty Officer	
Name of Disease	Malnutrition and Bronchitis		Date Admitted	14.8.42	Date Discharged	27.9.42

DATE	TREATMENT	REMARKS
14.8.42	Patient admitted to hospital complaining of weakness and aching feet. He had had two previous hospital admissions : on the 28.7.42 when he was admitted suffering from septic foot, discharged 31.7.42; and on the 8.8.42, when he was admitted suffering from Balanitis; dorsal slit was performed and he was discharged on 11.8.42. While in hospital he developed enteritis and from then onwards his course was steadily downhill.	Patient has been on milk diet
18.9.42	Patient developed Bronchitis. Morphia gr. ¼ was administered subcutaneously.	
26.9.42	Condition grew much worse. Respirations laboured. Morphia gr. 1/3rd injected H.T. Patient passed into semi-comatose condition.	
27.9.42	Patient died at 7.a.m. 27.9.42.	

(sgd) S.L. Bard,
Lieut., R.N.V.D.C.

Case No		Name of Diagnosing Doctor	Captain Coombes, R.A.M.C.		
Unit	Royal Navy	Nationality	British	Name and Rank	SINCLAIR, Charles Able Seaman
Name of Disease	(i) Septic Sores (ii) Malnutrition ~~(iii) Diphtheria.~~	Date Admitted	23.9.42	Date Died / ~~Discharged~~	3.55.a.m. 28.9.42

DATE	TREATMENT	REMARKS
23.9.42	Admitted from Main Ward with advanced Nasal, Faucial and Skin Diphtheria. AntiToxin 4000 units I.M. Trianon injection 4.c.c. 10% solution.	Had been in Main Ward with Chronic enteritis, Malnutrition and Multiple Septic Sores since 17.9.42. Condition Worse.
24.9.42	Repeat Trianon injection 4.c.c. AntiToxin 2500 units. Milk 1 Pint.	
25.9.42	Trianon Tablets 6. Bismuth gr. 20 b.d. Milk 1 Pint.	Diphtheria improved but general condition much worse.
26.9.42	Trianon Tablets 6. Repeat Bismuth mixture and Milk.	Tender. Toxaemia from Septic Sores.
27.9.42	Trianon Tablets 4. Repeat Bismuth mixture and Milk.	No improvement
28.9.42	Died 3.55.a.m.	Collapse and Death.

Case No		Name of Diagnosing Doctor		R.L. LANCASTER.	
Unit	Royal Marines	Nationality	British	Name and Rank	[illegible], James William Marine
Name of Disease	Malnutrition.	Date Admitted	1.8.42	Date Died Discharged	30.9.42 1.15.a.m.

DATE	TREATMENT	REMARKS
1.8.42	Full Diet. Yeast b.d.	Syncope. Pain in stomach and feet. Blurring of vision, Rt. eye. Pigmentation ankles, Chest wall, Flexor surfaces of arms. Insomnia.
25.8.42		
26.8.42	Inj. Morphine Tart. gr. ¼.	
30.8.42	Fresh Milk.	
1.9.42		Pain in feet severe.
2.9.42	Inj. Morphine Tart. gr. ¼	
4.9.42	Ephedrine gr. 1 per os.	Temporary relief
6.9.42		P.116
20.9.42	Diarrhoea.	Diarrhoea. Severe emaciation.
21.9.42	Diet : Milk and strained soup.	P.132. T.99. Considerable pain in left lower limb extending across abdomen to indefinite area in upper region. Diarrhoea : very frequent stools.
27.9.42	Inj. Morphine Tart. gr. ¼	
28.9.42	Inj. Morphine Tart. gr. 1/3rd. Inj. Coramine 1½ c.cs.	Vomiting black fluid. 10.p.m. collapsed.
30.9.42	Died at 1.15.a.m.	

(Sgd) R.L. Lancaster,
Captain, R.A.M.C.

Feathers
patient RM

00336

Case No		Name of Diagnosing Doctor		G.C. GRAY Jr.	
Unit	Winnipeg Grenadiers	Nationality	Canadian	Name and Rank.	[illegible], John Andrew Lieutenant
Name of Disease	[illegible] - Faucal	Date Admitted	29.9.42	Date Discharged	30.9.42 10.20 am

DATE	TREATMENT	REMARKS
30.9.42	Developed sore throat night of 24.9.42 at North Point Camp. On admission there was considerable membrane involving both tonsillar beds and extending up onto the soft palate. Membrane was present at the angles of the mouth.  Marked glandular swelling on right side of neck. Lot drinks & hourly.	Condition poor Patient died at 10.20 a.m. (sgd) G.C. Gray, Capt., R.C.A.M.C. 30.9.42.
30.9.42		

CASE NO:		NAME OF DIAGNOSING DOCTOR		H. U. Gray. Jr.			
UNIT.	W. T.	NATIONALITY	Canadian	NAME AND RANK	Corporal. Averach, J. A.		
NAME OF DISEASE	Diphtheria Faucal.			DATE:- ADMITTED	29.9.42.	DATE:- DISCHARGED	Died 30/9/42. 10.30 A.M.

DATE	TREATMENT.	REMARKS.
29.9.42.	Developed sore throat on night of 24/9/42 at North Point Camp. Admission there was considerable membrane involving both tonsillar beds and extending upon to the soft palate. Membrane was present at the angles of the mouth. Marked glandular swelling on right side of neck. hot gargles f.2.h.	Condition poor.
30.9.42.		Patient died at 10.30 A.M.

Capt. G.C.Gray.

Case No		Name of Diagnosing Doctor		C.C. Gray, Jnr.		
Unit	Royal Rifles of Canada.	Nationality	CANADIAN ~~English.~~	Name and Rank	Corporal. GIBBS, Douglas.	
Name of Disease	Enteritis.	Date Admitted	28.9.42.	Date Discharged	Died 1/10/42.	

DATE	TREATMENT	REMARKS
28.9.42.		Patient has had Acute Diarrhoea for 3 days with passage of blood and mucous. Very toxic on admission. Delirious and incontinent this evening.
	Trianon 4 c.c. intramuscularly 11.p.m.	
29.9.42.	.....2.c.c. ..... 10.a.m.	Condition poor. Semi-comatose.
30.9.42.		No improvement. Pulse feeble. Respirations somewhat laboured.
1.10.42.		Ceased to breathe at 8.00.a.m. 1/10/42.

(sgd. C.C. Gray).
Capt., R.C.A.M.C.

Case No		Name of Diagnosing Doctor	Dr. S.M. BARD.		
Unit	Merchant Service	Nationality	American	Name and Rank.	CHRISTENSEN, Harold. Seaman
Name of Disease	Auricular Fibrillation Myocardial Failure.	Date Admitted	25.9.42	Date Discharged	Died 1.10.42 5.10.p.m.

DATE	TREATMENT	REMARKS
25.9.42	Patient was admitted from Dysentery Hospital where he had A & B course of treatment. Patient was very weak with very irregular and feeble heart.	Patient had been on milk, fish, toast diet since admission.
27.9.42	Patient developed diarrhoea but no blood or mucous detected in the stools. Condition much worse.	
29.9.42	Temperature 100.2F. Inj. Morphia 1/3rd and Digitalin gr. 1/100th were given subcutaneously. Pulse was very bad.	
1.10.42	Patient died at 5.10.p.m. 1.10.42.	

(sgd) Solomon M. Bard,
Lieut., R.N.V.D.C.

Case No	Name & occupation	Details	etc. Army Fr.				
Unit	R.R.C.	Nationality	Canadian	Volume Page Number		Filey, Yorks.	
Voyage Journey	Diphtheria - nasal		Date Admitted	27/9/42.	Date Method used	1/10/42.	
DATE	TREATMENT					REMARKS	
27/9/42	Inc. sulph. 4 gms. ℞. 2 hrs. x 4.					Admitted to dysentery ward. blood and mucous in stool. 9 motions in 24 hrs. No cramps.	
29/9/42	not water gargles ℞ 2 hrs.					Developed sore throat this morning. membrane over right tonsillar possa 1 motion to-day.	
30/9/42	Hot water gargles ℞ 2 hrs.					membrane more extensive and extending onto buccal mucous membrane on both sides. marked cervical adenitis on right side.	
1/10/42	not gargles ℞ 2 hrs.					has some palatal paralysis. Membrane much more extensive. Moderate conunctivitis in right eye.	
	Morph. sulph. gr.¼ 9.30 P.M.					Condition poor. Pulse weak and irregular Patient died at 10.00 P.M.	

CASE NO. 1

No.	913		Name of Diagnosing Doctor		Major J.E. Swyer
Unit	H.K.V.D.Corps	Nationality	British	Rank	Lieutenant
				Name	A.C.I. Bowker
Name of Disease	Acute intestinal Obstruction	Date Admitted	2.10.1942	Date Discharged	Died 2.10.42.

Date	Treatment	Remarks
2.10.42	Admitted at 5.45 p.m. from Officers Prisoner of War Camp, Argyle Street. History: 2 days ago had abdominal distension and flatulence. Given enema with temporary improvement. Enema repeated the following day. No result. No vomiting. Atropine gr. 1/75 given with temporary relief. Today - Sudden deterioration in condition. Obstruction apparently complete. On admission: Patient palid with sunken eyes & cheeks, very weak pulse, considerable abdominal distension, no peristalsis, palpable MASS in left upper abdomen. Condition grave. Prepared for immediate operation. Gas and oxygen anaesthesia commenced 7.05 p.m. before induction was complete patient regurgitated large quantities of brown fluid and respiration commenced to fail. Foot of table immediately raised, throat cleared, artificial respirator maintained, coramine injected and trachea aspirated with ~~oath~~ Ⓧ Catheter. All efforts unavailing, and patient died at 07.35 p.m. Post mortem examination revealed a volvulus of the intestine, causing strangulation and gangrene of the ileo-caecal valve, appendix, caecum and ascending colon which had twisted and were lying in the left upper abdomen. Peritoneal cavity contained blood stained fluid. Small intestine distended with gas and fluid.	Stretcher

CASE NO. A

No.	913		Name of Diagnosing Doctor		Major J.E.Sayer
Unit	R.A.V.D.Corps.	Nationality	British	Rank	Lieutenant
				Name	A.C.I. Bowker
Name of Disease	Acute Intestinal Obstruction	Date Admitted	2.10.1942	Date Discharged	Died 2.10.42.

Date	Treatment	Remarks
2.10.42	Admitted at 5.45 p.m. from Officers Prisoner of War Camp, Argyle Street.	Stretcher

History:

2 days ago had abdominal distension and flatulence. Given enema with temporary improvement. Enema repeated the following day. No result. No vomiting. Atropine gr 1/75 given with temporary relief.

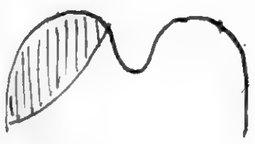
Today- Sudden deterioration in condition. Obstruction apparently complete. T.101.

On Admission: -

Patient palid with sunken eyes & cheeks, very weak pulse, considerable abdominal distension, no peristalsis, palpable more in left upper abdomen. Condition grave. Prepared for immediate operation. Gas and oxygen anaesthesia commenced 7.05 P.M. Before induction was complete patient regurgitated large quantities of brown fluid and respiration commenced to fail. Foot of table immediately raised, throat cleared, artifical respiration maintained. Coramine injected and trachea aspirated with cothetic. All efforts unavailing, and patient died at 07.35 p.m.

Post Mortem examination revealed a volvulus of the intestine, causing strangulation and gangrene of the ileo-caecal valve, appendix, caecum and ascending colon which had twisted and were lying the left upper abdomen. Peritoneal cavity contained blood stained fluid. Small intestine distended with gas and fluid.

Case No		Name of Diagnosing Doctor	G.C.Gray Jr.		
Unit	R.R.C	Nationality	Canadian	Name and Rank	Rifleman Kendall, Donald.
Name of Disease	Faucal Diphtheria - Nasal	Date Admitted	27/9/42	Date Discharged	Died 3/10/42 11.15 A.M.

DATE	TREATMENT	REMARKS
27/9/42	 No treatment.	Sore throat for 3 days before admission.
28/9/42	Hot gargles ¼ 2 h.	More membrane
29/9/42.	 Hot gargles ¼ 2 h.	Membrane largeer. Right nostril plugged. Some right cervical adenitis.
30/9/42	 Hot gargles ¼ 2 h.	Membrane extends up onto soft palate. uvula edematous and small patchyin membrane. small patch in left tonsillar fossa.
1/10/42	Hot gargles ¼ 2 h.	Condition same
2/10/42	Hot gargles ¼ 2 h.	Membrane more extensive Patient very toxic. Condition grave.
3/10/42		Patient died at 11.15 A.M. Acute circulatory failure. (Capt RCAMC).

Case No		Name of Diagnosing Doctor	[illegible] Banfill
Unit	R.R.C.	Nationality	Canadian
Name of Disease	Diphtheria Faucal	Date Admitted	2/10/42

Name and Rank: Rfm. McArthur J.E.

Date Discharged: Died 3/10/42

DATE	TREATMENT	REMARKS
2/10/42	Pot. permang. 1 : 1000 gargle every 2 hours. Membrane on both tonsils.	Sore throat since last night (about 8 hours.)
3/10/42	Mouth washes and gargles continued. Hot compresses to neck. Attempt made to remove membrane with forceps. Membrane on tonsils, soft palate and posterior Pharynx. No antitoxin available for treatment.	Short of breath. Difficulty speaking. Pallor of face and rapid thready pulse. Condition critical. 11.00 P.M. patient died.

Wm Banfill Capt.

CASE NO.		NAME OF DIAGNOSING DOCTOR	DOCTOR	S. M. Banfill.			
UNIT.	A.M. of Canada.	NATIONALITY	Candian.	NAME AND RANK.	Rfmn. MacArthur, J. E.		
NAME OF DISEASE	Diptheria Faucal.			DATE ADMITTED	2.10.42.	DATE DISCHARGED.	Died 3.10.42.

DATE.	TREATMENT.	REMARKS.
2.10.42.	Potassium Permanganate 1:1000 gargle every 2 hours. Membrane on both tonsils 	Sore throat since last night (about 8 hours.)
3.10.42.	Mouth washes and gargles continued. Hot compresses to neck. Attempt made to remove membrane with forceps. Membrane on tonsils, soft palate and posterior pharynx.  No antitoxins available for treatment.	Short of breathe, difficulty speaking. Pallor of face a and rapid thready pulse. Condition critical. 11 A.M. Patient died.

S. M. Banfill. Capt.

Case No		Name of Diagnosing	Doctor	Capt. S.M. Banfill			
Unit	R.R.C.	Nationality	Canadian	Name and Rank	Corporal Walsh, James Stanford.		
Name of Disease	Diphtheria - Faucial Ulceration of perineum		Date Admitted	30/9/42	Date Discharged	Died 5/10/42.	

DATE	TREATMENT	REMARKS
30/9/42	Continuous hot water compresses to perineum	History of Phobics itch for several months which recently became worse. Swelling of penis and scrotum and ulceration in groins and perineum.
1/10/42	Compresses continued.	Swelling lessening.
2/10/42	Compresses continued throughout. Patient isolated, potassium permanganate gargles used.	Sore throat. Membrane on left tonsil.
3/10/42	Swelling of uvula and spread to the other tonsil. Gargles and hot compresses.	Glands in neck enlarged Swallowing difficult. Condition serious.
4/10/42	Gargles and hot compresses.	Pulse weak and at times imperceptible. Breathing difficult, membrane wides read. Hemorrhagic bulla on neck. Ulceration of perineum extending.
5/10/42	Patient died at 4.30 A.M. Note: No diphtheria antitoxin available for treatment.	

S.M. Banfill Capt.

Case No		Name of Diagnosing	Doctor	Capt. J.A.G. Reid		
Unit	W.G.	Nationality	Canadian	Name and Rank	Private. Armstrong, George.	
Name of Disease	Pulmonary Embolus Secondary to groin ulcer.	Date Admitted	27/9/42	Date Discharged	Died. 5/10/42	

DATE	TREATMENT	REMARKS
27/9/42	Potassium permanganate compresses.	Large ulcer 4"X4" in rt. groin with much sloughing Small ulcers over both buttocks.
28/9/42	Potassium permanganate compresses.	Ulcer cleaner.
29/9/42	Pot. permang. compresses with heat applied over dressing.	Ulcer cleaner.
30/9/42	Pot. permang. and heat	Ulcer clean and healing
1/10/42	Pot permang. and heat	Ulcer healing
2/10/42	Pot. permang. and heat	
3/10/42	Pot. permang. and heat. Fluid diet.	Had 2 loose stools. Ulcer closing.
4/10/42	Pot. permang. and heat.	2 loose stools. Ulcer closing.
5/10/42	Pot. permang. and heat Heat to belly. As little activity as possible.	Ulcer closing. Pain in belly with tenderness in R L Q.
	10.35 A.M. Was helped to toilet by 2 orderlies and suddenly gasped and collapsed. Immediately died. - Pulmonary embolus from abd. thrombophlebitis. Secondary to ulcerated groin.	

Case No		Name of Diagnosing Doctor	Dr. S. [illegible]
Unit	[illegible] Defence Corps	Nationality	British
Name and Rank	[illegible] Private		
Name of Disease	(i) Broncho-Pneumonia (ii) Malnutrition.	Date Admitted	17.9.42
Date Discharged	[illegible] 5.10.42 Died.		

DATE	TREATMENT	REMARKS
17.9.42	Patient admitted to the Hospital suffering from malnutrition and diarrhoea. He was put on Fluid Diet first and then on Milk Diet.	Diet - Milk, Toast, Strained Soup and Cornflour.
1.10.42	Patient was put on sulphapyridine. Total of 3 grs. was given. Diarrhoea improved considerably and almost stopped. General condition began to improve slightly.	
5.10.42	Suddenly collapsed at [illegible].30 a.m. Temperature rose to 103°. Pulse 160 a minute. Respirations 60/min. Examination of chest revealed extensive Broncho-Pneumonia. Condition became very bad. Coramine [illegible] was given I.V.I. Atropine 1/75th was given [illegible]. Patient steadily failing.	
	Patient died at 1.40 a.m. 5.10.42.	
	(Sgd) S. [illegible], Lieut.	

Case No		Name of Diagnosing	Doctor	Capt. G.C. Gray Jr.	
Unit	Royal Rifles of Canada.	Nationality	Canadian	Name and Rank	Rifleman. Welsh, Delbert L.W.
Name of Disease	Diphtheria - Laryngeal	Date Admitted	29/9/42	Date Discharged	Died 5/10/42 11.15 P.M.

DATE	TREATMENT	REMARKS
29/9/42		Sore throat - 24 hours.
30/9/42	 Hot gargles ¼ 2 h.	Small patch of membrane behind each posterior pillar.
1/10/42	Hot gargles ¼ 2 h.	Membrane has increased slight bilateral cervical adenitis.
2/10/42	 Hot gargles ¼ 2 h.	Uvula edematous. Membrane larger.
3/10/42	Hot gargles ¼ 2 h.	Membrane increasing.
4/10/42	Hot gargles ¼ 2 h.	Membrane larger. More extensive glandular involvement.
5/10/42	 Hot gargles ¼ 2 h.	Membrane much more extensive. Marked periadenitis - bull-neck. Can not swallow. Increasing toxicity and difficulty breathing. Died at 11.15 P.M.

Case No	Volume of Wounding	Bullet	Nature of Injuries	Unit	Weight Disease	Date	Treatment	Remarks
1.C.42	Ho wound. Throughout end Sodii Iodid. Ho wound. Throughout end Sodii Iodid.							
2.C.42	Phlegmon l.c.c. extent two dcms for 6 dcys. Vocaine by mouth.							
3.C.42	Adrenalin l.c.c. 1/1000 solution S.C.I. Strychnine ½ dose of 1/30th grn. S.C.I. Thin in l.c.c. drill for 6 dcys.							
4.C.42	Pituitrin l.c.c. 3 doses 1 hourly intervals.							
5.C.42	Vitamin C. Tablets 2 x day. Sodii Salicyl. gr. 20 t.i.d. in hot water. Strontine Fr. 1/30th S.C.I. at 9.0.a.							
6.C.42	Vitamin C. Tablets 2 x day. Sodii Salicyl. gr. 20 t.i.d. in hot water. Strontine Fr. 1/30th S.C.I. at 9.0.a.							
7.C.42	Vitamin C. Tablets 2 x day. Sodii Salicyl. gr. 20 t.i.d. in hot water. Strontine Fr. 1/30th S.C.I. at 9.0.a.							
8.C.42	Vitamin C. Tablets 2 x day. Sodii Salicyl. gr. 20 t.i.d. in hot water. Strontine Fr. 1/30th S.C.I. at 9.0.a.							
9.C.42	Vitamin C. Tablets 2 x day. Sodii Salicyl. gr. 20 t.i.d. in hot water. Strontine Fr. 1/30th S.C.I. at 9.0.a.							
10.C.42	No. Antitoxin available. Treated with Penicillin 1/500 solution and of Rot. Permang. 1/5000. Lotn. Sodii Cit. gr. 10 b.d. Chloral Hyd. 30 g.m.							

CASE NO.

No.	821		Name of Diagnosing Doctor		Major. J.W.Anderson R.A.M.C.
Unit	R.C.A.S.C.	Nationality	Canadian	Rank	Sgt.
				Name	Pierce, W.R.
Name of Disease	Gangrene of toe Septic Blisters arms & legs.	Date Admitted	19.9.42	Date Discharged	Death 6.10.42.

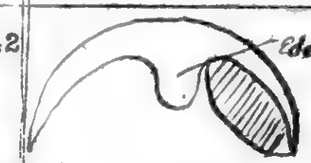
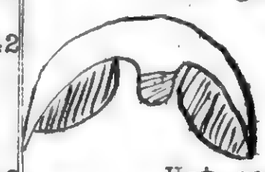
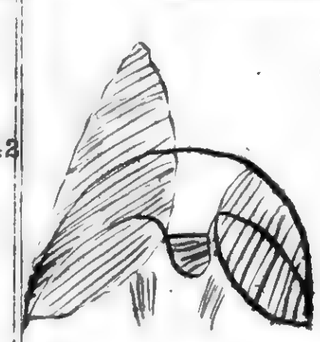
Date	Treatment	Remarks
19.9.42	Gangrene of L. Great toe as result of septic scratch. Multiple septic blisters both forearms, legs & thigh. Glycerin & Mag. Sulphat to all sores. Dry dressing to gangrene. Sulphonamide 2 tablets, three times daily for 4 days.	Stretcher
24.9.42	Sore mouth: glycerin & borax. Trianon chloride 10mgm. twice weekly. Lusol to sores - day - Triple ointment night. Mist 2/15 ½ at night for pains in arms.	
2.10.42	Gangrenous area - slough separating. Triple ointment.	
6.10.42	Was quite comfortable until evening when he complained of epigastric discomfort. at 9.24 p.m. died suddenly without warning while at stool. Postmortem:examination: Heart generally enlarged. Aortic valve & aorta normal. No clots or abnormal appearances in pulmonary vessels. Mitral valve hardened but not & no actual evidence of incompetence. "Nutmeg" appearance on cross section of liver -- chronic venous congestion of liver. No other post-mortem appearance of note. Cause of death: Primary: Mitral valvular disease. Secondary: (a) gangrene of toe. (b) Acute heart failure. J. W. Anderson, Major, R.A.M.C. 7/10/42.	

Case No		Name of Diagnosing Doctor	Capt. S. M. Banfill.				
Unit	Winnipeg Grenadiers.	Nationality	Canadian.	Name and Rank	Pte. Robidoux, Marcel, L. J.		
Name of Disease	Diphtheria - Faucial.	Date Admitted	Oct. 2/42	Date Discharged	Died. Oct. 7.42.		

DATE	TREATMENT	REMARKS
Oct. 2.	Potassium Permanganate gargle.	Membrane on both tonsils.
Oct. 3.	Potassium Permanganate gargle.	Membrane on left side spreading widel small membrane on right tonsil.
Oct. 4.	Potassium Permanganate gargle.	Large membrane on left tonsil. Palate and uvula with much swelling and interference with breathing. Glands large on left side.
Oct. 5.	Potassium Permanganate gargle.	Membrane extending all over soft palate. Glands much enlarged. Cannot swallow water.
Oct 6.	Potassium Permanganate gargle.	Throat closed as above, pulse very weak. Placed in room by himself.
Oct 7.	Antitoxin was not available to treat this case.	Died at 2.45 A.M.

Sgd. Banfill Capt.

Case No		Name of Diagnosing Doctor	G.C.Gray M.
Unit	W.G.	Nationality	Canadian
Name and Rank.	Mabb,Herbert,H.,Pte.		
Name of Disease	Faucial Diphtheria:Laryngeal	Date Admitted	29/9/42.
Date Discharged	Died 1.00pm 7/10/42		

DATE	TREATMENT	REMARKS
29/9/42	 Hot gargles q.2.h.	sore throat-2 days. Mild left cervical adenitis.Difficulty in phonation.
1/10/42	Hot gargles q.2.h.	No appreciable change.
3/10/42	 Hot gargles q.2.h.	More extensive membrane. Bilateral cervical adenitis.
4/10/42	Hot gargles q.2.h.	Membrane appearing on posterior wall of pharynx.
5/10/42	 Hot gargles q.2.h.	Much more membrane. Difficulty in breathing. Periadenitis more marked.
6/10/42	Hot gargles q.2.h.	Very weak and toxic. Pulse thready.Increasing difficulty in breathing.
7/10/42	Hot gargles q.2.h.	Condition hopeless. Cyanosed,pulseless. Acute cardiovascular collapse.Died 1.00 p.m.

(Capt. R.A.M.C.).

Case No		Name of Diagnosing Doctor		Capt. S.M. Banfill.			
Unit	R R C	Nationality	Canadian	Name and Rank	Rfn. Welsh, A. B.		
Name of Disease	Diphtheria, faucial		Date Admitted	Oct.1/1942	Date Discharged	Died Oct 7.	

DATE	TREATMENT	REMARKS
1/10	Potassium permanganate gargles.	Membrane on right tonsil.
2/10	Potassium permanganate gargles	Membrane spread to other tonsil and uvula.
3/10	Potassium permanganate gargles	Condition markedly toxic; much swelling on right side and glandular swelling.
4/10	Potassium permanganate gargles.	Condition unchange
5/10	Gargles as above.	Unable to swallow. Throat completely blocked with swelling. Marked glandul swelling.
6/10	Gargles.	Heart failing. Patient removed to room by himself.
7/10	Gargles.	Pulse imperceptible. Delerious.Neck very swollen. Died at 5.30 PM.

Note: No antitoxin was available for this patient.

S.M. Banfill Capt

Case No		Name of Diagnosing Doctor	G.C.Gray,Jr.		
Unit	R.R.C.	Nationality	Canadian	Name and Rank	BARCLAY, Wm. Rifleman.
Name of Disease	(1) Acute Enteritis. (2) Acute Parotitis.	Date Admitted	29.9.42	Date Discharged	Died 7.10.

DATE	TREATMENT	REMARKS
29.9.42	History: Diarrhoea and Abdominal cramp 4 days. On admission, toxic,dehydrated and ~~semidiarian~~ semi-comatose. Stool: Greenish mucous, some blood.	
30.9.42:	Trianon - 3 cc intramuscularly. Condition poor,pulse feeble.	
1.10.42:	Trianon - 2 cc intramuscularly. Incontinent by bowel.	
2.10.42:	Full bed care. Vomiting nearly everything taken by mouth. Still incontinent.	
4.10.42:	Pustular eruption over back. Quite confused mentally.	
6.10.42:	Full bed care. Sudden bilateral enlargement of parotid glands. Tender and non fluctuent. Condition grave.	
7.10.42.	Semi-comatose, pulse very thready. Died at 7.00 P.M.	

G.C.Gray Jr.
(Capt. RCAMC).

Name and Diagnosing Doctor: G C Gray, Jr.
Unit - Winnipeg Grenadiers.
Nationality:- Canadian
Name and Rank: MOORE, Wilfred S. Private.
Name of Disease:- Diphtheria, faucial.
Date admitted- 30.9.42
Datedischarged:- Died, 9.10.42

Date:	Treatment:	Remarks.
30.9.42	History: Sore throat 12 hours. Nose plugged bilaterally, membrane on left tonsil. Left cervical adenitis. Marked dermatitis of right leg and scrotum, with secondary infection.	
	Hot gargles q.2.h. Elevation of right leg. Moist Lysol dressings to skin lesions.	
1.10.42:	Treatment as above.	Throat same. Membrane now involving both lips.
2.10.42	" " "	Mouth worse.
3.10.42	" " "	Much worse, Cannot open mouth sufficiently to see throat.
4.10.42	Continual moist Pot Permang. Dressings to legs and scrotum. Elevate right leg. Hot gargles q.2.h.	
		No improvement.
5.10.42	Treatment as before.	Condition same.
6.10.42:	" " "	Membrane apparantly affecting ~~larx~~ larynx. Bilateral cervical adenitis Difficulty in breathing. Condition poor.
8.10.42:	" " "	Glandular enlargement much greater
9.10.42	" " "	Died 8.00 A.M.

Capt

CASE NO. 1

No.	879.		Name of Diagnosing Doctor		Major G.F.Harrison. R.A.M.C.
Unit	R. W. G.	Nationality	Canadian	Rank	Private
				Name	COADY, J. A.
Name of Disease	1.Diptheria(throat) 2.Heart Failure.	Date Admitted	23/9/42	Date Discharged	Death: 9/10/42 at 1.08.A.M.

Date	Treatment	Remarks
23/9/42	Complains of sore throat for 1 day. No previous illness. Onset of present trouble was sudden. On Examination: There is a grey, slimy exuadte on both tonsils. Slight glandular enlargement of neck. Heart sounds are normal; knee & ankle reflexes present and equal. Treatment: Hot irrigations to throat and mouth washes. Thiamin Chlordie 10.mgms every day.	Stretcher.
24/9/42	Lab: Report on Thraot Swabs: "No Vincent's organisms seen. Diphtheroids present resembling Klebs Loefflers Bacilli".	
25/9/42	Throat is much worse. The appearance is that of Diphtheria. The membrance has spread to cover the uvula. Is grey in color and is stinking. The glands of the neck, on each side are grossly enlarged. Treatment: 375.ccs of blood from a convalescent diphtheria case was transfused into the patient.	
26/9/42	Feels much better;general condition better. Throat appears better. Heart sounds are normal.	
27/9/42	Still imrpoving. Heart sounds are normal. Pulse rate slow. Treatment: Start ascorbic acid tablets 2 per day. Repeat hot irrigations.	
29/9/42	Feels all right. Throat much better. Heart sounds normal.	
30/9/42	Throat still feelsrather sore. Some bleeding from left nostril.	
1/10/42	Heart sounds normal (slow & strong).	
2/10/42	Some mucopus at back of throat;otherwise throat is clean. Heart -- at the apex, the first & second sounds are of equal intensity. Treatment: Coll..alkalinus solution to nose,which is blocked.	
3/10/42	Feels "very good" this morning. Throat clean;heart -- at the apex the second sound is of greater inetnsity than the first.	
4/10/42	Complains of a feeling of pressure on his chest,which he has had for the last two days. On examination,lings - clear; heart sounds as before.	
5/10/42	Feeling of pressure on chest is going. Heart sounds as before.	
Afternoon:	Vomited one living roundworm from his throat this afternoon.	
6/10/42	Feels much better. Heart sounds appear normal.	
7/10/42	Feels well. Heart sounds are normal but the pulse rate has become more rapid & the pulse is more compressible. Throat is perfectly clean.	
7/45.PM.	Had a sudden epileltiform convulsion of a minor nature. Head and eyes were truned to one side. No warning. Was confused when he regained consciousness. On examination - Heart - the sounds are now in quadruple rhythm(i.e.there is reduplication of the first and the second sound at the apex).	

CASE NO. 7 Private COADY, J. A.

No.		Name of Diagnosing Doctor	
Unit	Nationality	Rank	
		Name	
Name of Disease	Date Admitted	Date Discharged	

Date	Treatment	Remarks
7/10/42 7.45.PM.	Treatment: 20 ccs of 50% glucose given intravenously.	
8/10/42	Slept well; feels well. Heart -- quadruple rhythm still present.	
11.00.AM.	Sudden epileptiform fit. On examination -- Heart sounds are compeletly irregular and slow. At times, the heart stops completely, causing yet another fit. (Stokes - Adams syndrome). There was a long session of minor fits. Each fit was cuased by the heart stopping. His color become ashen-grey and he was covered with sweat. Cold extremities. Some cyanosis.	
	Treatment: 8.15.A.M. -- 20 ccs 50% glucose given intravenously. 11.00.A.M. -- Adrenalim minims 5 given twice subcutaneously. Hot water bottle to praecordium. End of bed placed on chairs. 1.00.P.M. Ephedrine grains ½. 5.30.P.M. Ephedrine grains ½. 7.00.P.M. Ephedrine grains ½.	
	Bewteen 4.00 & 6.00 P.M.,there were similar attacks. In bewteen attacks, his general condition appears moderately. satisfactory.	
7.00.P.M.	Retching and vomiting.	
7.10.P.M.	Passed one small stool.	
	Treatment: Between 4.00 to 6.00.P.M. 5 minims of adrenalim were given three times. 6.00.P.M. Strychinine-hydrochloride 1/60 grain subcutaneously.	
10.30.PM.	General conditon fair. Heart sounds strong & regular. Merely complained of painful feet.	
9/10/42	1.08.A.M. -- The patient had one further spasm and died.	

Signed: G.F.Harrison.

Major--- R.A.M.C.
Medical Specialist.

CASE NO. 2

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	Pte.
				Name	J. A. Coady.
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks

Continuation:

The Post Mortem on the body of the late Pte. J.A. Coady showed:

Throat - - Clean.
Trachea - - Clean.
Lungs - - Normal.
Heart - - Appeared rather large; weight 15¼ oz. Right side rather dilated. Large premortem clot in both ventricles. Valves, normal. Muscle, normal.
Liver - - Normal.
Kidneys - - Deeply congested; otherwise normal.
Spleen - - Normal.

Conclusion: This patient died from the late effects of diphtheria. Presumably, the heart irregularity and the final cessation of the heart beat was due to nerve injury, the result of the diphtheria toxin.

G.F. Harrison,

Major - R. A. M. C.

Medical Specialist.

CASE NO. 553

No.	10630		Name of Diagnosing Doctor		Kartar Singh Jemadar, I.M.D.
Unit	5/7th R.R.	Nationality	Indian	Rank	Sepoy (age = 29).
				Name	Amal Singh
Name of Disease	Ankylostomiasis	Date Admitted	6.8.42.	Date Discharged	Died at 8.45. on 9.10.42.

Date	Treatment	Remarks
6.8.42	c/o fever with shivering. -- Duration = 20 days. Spleen: - Palpable on deep respiration. Heart & Lungs:- Normal. Anaemia + + Blood for M.P. Stools for Ova. & exudate } Negative. Re. Mist A.P.C. 0ji Re. Mist Quinine 0ji B.D.	Milk 13.8.42- Bottle 1
11.8.42	Stop Quinine. Re. Mist Iron Tonic 0ji. B.D. Thiamine 1/2 cc. S.C.	
13.8.42	Stools ova of Ankylostoma Poly normalilost, Poly chromatophilia, Punctate hesophilia { R.B.C = 1,875,000 W.B.C = 3,600 C.1 = 12 H.b % = 45 P = 55 L = 43 M = 2	
15.8.42.	Course for worms to be given.	
17.8.42.	Oil of chenopodium and chl given.	
18.8.42	One round worm passed. Blood for M.P. = Negative.	
19.8.42	Feeling little better.	
22.8.42	Feeling better.	
24.8.42.	Oil of chenopodium MXV	
27.8.42.	Feeling better.	
1.9.42.	Improving. Stools for E. H. & Ova. = Negative	
8.9.42.	Weakness increasingly.	
8..42.	Found low fever.	
20.9.42	Puffiness of the face increased.	
25.9.42	Condition same.	

00362

Date	Name of Wounding	Details	Unit	Name and Address	Date	Nature of Disease	Date	TREATMENT	REMARKS

00365

	NAME OF DIAGNOSING DOCTOR	DOCTOR	Capt. G.C. Gray Jr.		
The Winnipeg Grenadiers	NATIONALITY	Canadian	NAME AND RANK	PEARSON, Douglas Edwin Private	
Diphtheria - Faucial - Lingual - Buccal		DATE ADMITTED	1/10/42	DATE DISCHARGED	Died 12/10/42

Oct. 1	Boracic eye washes q. 2 h. Continual most boracic compresses 	Admitted with history of conjunctivitis (left eye) for one week, becoming worse three days before admission. Exam. dendritic ulcer of left eye. Membrane at both angles of mouth and on both tonsils and tongue.
Oct. 2	Boracic eye washes and compresses	Membrane more extensive.
Oct. 3	" " " " "	Condition same
Oct. 4	" " " " " Hot gargles q. 2h.	Increased membrane
[redacted]		
Oct. 5	Boracic for eye and hot gargles q. 2 h.	Left eye completely closed and secondary infection of skin below lower eyelid. Tongue now involved with membrane. Face swelling.
Oct. 7	Boracic for eye. Hot gargles q. 2 h.	Marked generalixed edema of face. Tongue and buccal mucous membrane involved.
Oct. 9	Boracic for eye. Hot gargles q. 2 h.	More extension of membrane. Palatal paralysis. Condition poor.
Oct. 11	Boracic for eye. Hot gargles q. 2 h.	Some tendency to hemorrhage from membranous areas. Heart sounds feeble.
Oct. 12	Boracic for eye. Hot gargles q. 2 h.	Died at 7:00 P.M. (Capt. RAMC)

	NAME OF DIAGNOSING DOCTOR	Capt. J.A.G. Reid	
Royal Rifles of Canada	NATIONALITY	Canadian	NICHOLSON, William Rifleman
Acute Enteritis	DATE ADMITTED	4/10/42	Died 13/10/42

TREATMENT

Oct. 4	Mag. Sulph. ℥ss q. 2 h. Fluid diet.	Bed, rest	Frequent small watery stools, 15 in the day and 10 at night
Oct. 5	Fluid diet. Heat to belly.	Bed, rest	Stools as before, 10 by day, 8 by night
Oct. 6	Fluid diet. Heat to belly.	Bed, rest	Stools less frequent, 8 by day 4 by night.
Oct. 7	Light diet.	Bed, rest	Slime and small amount of pus in stools, 6 by day, 4 by night.
Oct. 8	Fluid diet. Mag. Sulph. ℥ss	q. 2 h.	Stools more frequent with slime and pus. Patient very weak.
Oct. 9	Light diet.	Bed, rest. Push fluids	Patient very weak. 6 stools by day and 6 by night.
Oct.10	Light diet.	Bed rest. Push fluids	Stools less frequent and small but patient is weak and delerious to-day.
Oct.11	Light diet.	Bed rest. Push fluids	Patient disorientated and incontinent. Pulse very weak.
Oct.12	Light diet.	Bed rest. Push fluids	Patient disorientated and incontinent. Moribund.
Oct.13			Patient lapsed into coma and died at 2:30 A.M.

Cause of death - Acute Enteritis

J.A.G. Reid Capt

NAME OF ATTENDING DOCTOR		Capt. G.C. Gray Jr.	
UNIT	The Winnipeg Grenadiers	NATIONALITY	Canadian
NAME IN RANK		THOMASSON, Thomas August Private	
DISEASE	Diphtheria - Faucial - Laryngeal	DATE ADMITTED	27/9/42
DISCHARGED		Died 14/10/42 4:00 a.m.	

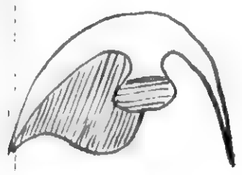
TREATMENT

REMARKS

27 Sept.	Gargles q. 2 h.	Sore throat - 1 day
29 Sept.	 Hot gargles q. 2 h.	Patchy membranous areas over each tonsil. Bilateral orvical adenitis. Marked conjunctivitis of left eye.
1 Oct.	Hot gargles q. 2 h. Boracic eye washes and comresses q. 2 h.	Conjunctivitis much worse. Now beginning in right eye. More edema of uvula and soft palate.
3 Oct.	Hot gargles, boracic eye washes and compresses q.2.h.	More membrane. More edema. Increased adenitis. Very hoarse, Larynx involved.
5 Oct.	Treatment as before	Eyes worse. Membrane appearing on post. pharyngeal wall. Peridenitis
7 Oct.	Treatment as before	Throat and eyes appear better but patient weak Pulse not of good quality
9 Oct.	Treatment as before	Palatal paralysis present. Cannot eat. Throat has less membrane but he is <u>very</u> toxic. Condition poor.
11 Oct.	Treatment as before	General condition worse Outlook grave
13 Oct.	Treatment as before	Condition same
14 Oct.		Died at 4:00 A.M.

Capt. R.C. Mayo

	NAME OF DIAGNOSING DOCTOR	Capt. G.C. Gray Jr.	
Royal Rifles of Canada		Canadian	SAUSON, Edward Lewis Lance-Serjeant
Diphtheria - Faucial - Laryngeal	DATE ADMITTED	27/9/42	Died 4:30 P.M. 14/10/42

27 Sept.	 Hot gargles q. 2 h.	Sore throat - 1 day Right cervical adenitis
28 Sept	 " " "	Membrane larger. Glands bigger.
1 Oct.	" " "	Unimproved
3 Oct.	 " " "	Membrane more extensive Uvula now covered. Glands a little smaller Swelling present above jugular notch. Very hoarse. Right nostril and larynx involved.
5. Oct.	" " "	A little less membrane. Sloughs foul. Very toxic.
7 Oct.	" " "	Throat looks better but general condition poor.
9 Oct.	 " " "	Some membrane on post. pharyngeal wall. Adenitis much less. Patient not eating. Pulse weak and thready.
11 Oct.	" " "	Condition still grave.
13 Oct.	" " " c	Much weaker. Has developed partial heart block. (3 : 1)
14 Oct.		Died at 4:30 P.M.

Capt. R.C.A.M.C.

Rank & U/C		Name of Diagnosing Doctor		T.L. LANCASTER.	
Unit	2nd Bn. The Royal Scots	Nationality	British	Name and Rank.	MILN, CHARLES. PRIVATE
Name of Disease	Pulmonary tuberculosis.	Date Admitted	13.9.40	Date of Death or Discharged	14.10.40

DATE	TREATMENT	REMARKS
13.9.40		Admitted with pyrexia of unknown origin.
14.9.40		Transferred to Royal Naval Hospital. Condition: Extreme emaciation. Chest with normal bronchial breath sounds. Much tenacious sputum. Signs of tuberculous focus at left apex. Loss of weight. Night sweats not elicited. Evening temperature run in between 99.0° and 103°. Incontinence of faeces.
7.10.40	Mx. Potassium mixture t.d.s. Chloral mx. xx ccs. p.r.n. Full diet. Milk. Bromalgin. Thiamine injection 2 c.cs. alt. die.	
12.10.40	Strychnine mx. 1/100 injection 6 hourly.	
13.10.40	Morphine mx. ¼ injection.	Sinking condition.
14.10.40	Died at 1.30 a.m.	

(sgd) T.L. Lancaster,
Captain, R.A.M.C.

Date	Treatment	Remarks
17.9.42	Patient admitted suffering from Influenza and slight diarrhoea. Left in bed and otherwise treated. No ??? Medicine ? ???	
17.10.42	Seen by Med. Spec. Direction of the first case. Fully ? ??? and ??? Ind ??? on ??? ???	
18.10.42	Patient ??? ??? ??? ??? ???	

(Pte) S.I. Jones. Lieut.

Unit	Name	Ward or Location	Date Admitted	Date Discharged
		Ward or Location	Duties	Dr. S.I. Jones.
Unit	Name	Ward or Location	Date Admitted	Date Discharged

CASE NO. 1773

No.	13864		Name of Diagnosing Doctor		Kanta Singh Jemadar, I.M.D.
Unit	2/14 P.R.	Nationality	Indian	Rank	Sepoy
				Name	Gul Akbar (age:25 yrs).
Name of Disease	Beri Beri	Date Admitted	29.9.42.	Date Discharged	Died at 15.25 hours on 14.10.42.

Date	Treatment	Remarks
29.9.42.	Patient has been received in an exhausted state complaining of fever with shivering and pain in abdomen. Duration: 15 days. Patient states he has been suffering from peculiar feelings in the epigastrium for over two months and has since been conscious of loss of health and vitality. During the past 15 days he has been getting irregular attacks of fever, sometimes in the morning and sometimes in the evening of course with shivering everytime. Examination Patient looks pale with conjunctivae, lips and nails more or less bloodless. Tongue coated and dry. Heart and lungs normal. Spleen enlarged and hard ++ L.P. Beam. Emaciation of leg muscles marked. Knee jerks lost with loss of sensations over tibae. Temp 100 F., Pulse 90. Resp. 24 p.m. Blood for M.P. Negative. Stools for ova - Negative. Mist M.P.C. ½i stat Thiamine ½ cc daily for 3 days.	
30.9.42	Patient states he feels better. Temp. normal.	
1.10.42	Blood for M.P. Negative.	
3.10.42	Blood for M.P. Negative.	
5.10.42	Still Fever. Lungs clear.	
11.10.42	Fever. Blood for M.P.-- Negative. Urine for general examination.	
12.10.42	Nil abnormal. Weakness increasing.	
13.10.42	Condition very very serious.	
14.10.42	Cardiac Asthma. Condition very very serious. Died at 3.25 P.M. Kanta Singh. Jem. I.M.D. Chetan Dev, Jemadar, I.M.D. Commanding Officer Bunker Sho.	

CASE NO. 553 (Continue).

No.	10630		Name of Diagnosing Doctor		Kantar Singh Jemadar, I.M.D.
Unit	5/7th R.R.	Nationality	Indian	Rank	Sepoy (age = 29)
				Name	Aval Singh
Name of Disease	Ankylostomiasis	Date Admitted	6.8.42.	Date Discharged	Died at 8.45. on 9.10.42.

Date	Treatment	Remarks
30.9.42	Condition getting bad.	Milk. 1 bottle.
5.10.42	Fever. Blood for M.P. Negative.	
8.10.42	Blood for M.P. Negative. Oedema increasing - General conditon worse. Urine for general examination. Nil abnormal.	
9.10.42	Condition. Very Grave.	
	Died at 8.45. P.M.	
	Chetan Dev. Jemadar, I.M.D., Commanding Dai Bunken Sho, 10-10-42.	

CASE NO.		NAME OF DIAGNOSING DOCTOR.		Capt. Coombes R.A.M.C.			
UNIT	HKVDC.	NATIONALITY.	British	NAME AND RANK.	Corporal Budden, Gilbert.		
NAME OF DISEASE	1. Heart Failure. 2. Diphtheria. 3. Disseminated Sclerosis.			DATE ADMITTED	18/9/42.	DATE DISCHARGED	Died :5.30A.M. 11/10/42.

DATE.	TREATMENT.	REMARKS.
18/9/42.	Admitted from Main Ward of Hospital where he had been for 7 weeks with spastic paralysis probably due to Disseminate Sclerosis.	Diphtheria fancial right side mild.
19/9/42.	Antitoxin 5000 Units given. Thiamin injection 10 mgms daily.	General condition very poor. Emaciated Incontinent and paralysed.
20/9/42.	Bismuth gr. xx tid. Betabolin 2 cc daily injection.	Improvement in Throat.
22/9/42.	Mouth cleaned with Sodi Bicarb. Eyes treated with Boric Acid 4% Bismuth and Betabolin	No membrane now present. Can swallow with difficulty.
30/9/42.	Daily doses of Bismuth gr. xx. Injections of Betabolin 2 cc every 2nd day. Treatment to eyes and mouth daily. Feeding by spoon. Morphine powder for diarrhoea gr. ¼ .	Some improvement in general condition able to speak better and move arms and legs a little very incontinent still.
7/10/42.	Betabolin injections discontinued. Bismuth tid as above. Morphine ¼ gr. by mouth nocte.	Condition much the same. Eyes troublesome mouth dirty. Became suddenly worse.
8/10/42.	Coramine 1.7 cc injected. Continued above treatment.	
10/10/42.	Strychnine gr.1/30.	
11/10/42.	Died 5.30 A.M.	Sudden cardiac collapse - DIED.

Capt. Coombes R.A.M.C.

CASE No:		NAME OF DIAGNOSING DOCTOR		G. C. Gray, Jr.		
UNIT.	Winnipeg Grenadiers.	NATIONALITY	Canadian.	NAME AND RANK	Pte. Iles, P.J.	
NAME OF DISEASE	1.Diphtheria. 2.Acute Enteritis.	DATE ADMITTED	7/10/42	DATE DISCHARGED	Died 11/10/42 12.30.A.M.	

DATE	TREATMENT.	REMARKS.
7/10/42	Admitted with brisk diarrhoea - 15 Or 20 bowel movements in previous 24 hours accompanied by cramp. No blood seen in stool at this time.	
	Mag.Sulph. 4.0.gm. f.2.h. x 4.	Fluid diet.
8/10/42	Mag.Sulph. 4.0.gm. f.2.h. x 2. Fluid Diet. Aspirin 0.6 gm. t.i.d.	No decrease in diarrhoea. Still severe complains of tightness across front of chest. Nothing sound on examination.
9/10/42	Hot gargles f.2.h. 5,000. units Anti-toxin.	Blood and mucous in stool today. Examination of throat revealed large membrance over left tonsil and two small patches over right. Bilateral cervical adenitis.
		
10/10/42	Hot gargles. f.2.h.	Patient [illegible]. Very toxic. Outlook grave.
11/10/42		Patient died at 12.30.A.M.

Sgd: G. C. Gray, Jr.
Captain, R.A.M.C.

0038

CASE No:		NAME OF DIAGNOSING DOCTOR		G. C. Gray, Jr.			
UNIT.	Royal Rifles of Canada.	NATIONALITY	Canadian.	NAME AND RANK	Rfn: Huntington, R.		
NAME OF DISEASE	DIPHTHERIA Lingual Buccal.		DATE ADMITTED	3/10/142	DATE DISCHARGED	Died 11/10/42 8.30.P.M.	

DATE	TREATMENT.	REMARKS.
3/10/42	Admitted with a diphtheritic membrance on lips only. This was treated with Pot.Permanganate mouth washes.	
7/10/42	Membrance appearing on tongue and buccal mucous. Pot.Permang.mouth washes f.2.h.	
8/10/42	Marked bilateral cervical adenitis and swelling of face. Pot.Permang.mouth washes f.2.h.	
9/10/42	Condition worse. Same treatment.	
10/10/42	Edges of eyelids involved by membrance. Both eyes closed. Whole tongue, lips and most of buccal mucose appear to be involved. Face much more Swollen. Toxemia very severe. Outlook grave. Treatment as before.	
11/10/42	Condition much worse. Involved areas showing haemorrhagic tendencies. Very toxic. Died at 8.30.P.M.	

Sgd: G. C. Gray, Jr.
Captain, R.A.M.C.

CASE NO:		NAME OF DIAGNOSING DOCTOR	DOCTOR	Capt. Coombes. R.A.M.C.			
UNIT.	R.N.	NATIONALITY	British.	NAME AND RANK.	Able Seaman. Pearson. Monthrue.		
NAME OF DISEASE	Nasal and Skin Diphtheria.			DATE:- ADMITTED.	30/9/42.	DATE:- DISCHARGED	Died :1.40 P.M. 12/10/42.

DATE	TREATMENT.	REMARKS.
30/9/42.	Antitoxin 6500 Units I.M. Nasal Douches with Sodi Bicurb. gr. x to oz.1 water. Carboles with Carbolic 1 in 200. Lusol dressing to buttock bd.	Admitted from Main Ward where had been in for 5 days suffering from septic sore of buttock and "cold in the nose".
1/10/42.	Continue all above treatment and dressing. Aspirin gr. X nocte.	Improvement in nasal condition. Heals well. Buttocks cleaning up.
5-7.10.42.	Continue treatment to nose and buttocks Gentian Violet 2% to buttocks bd.	Much improved generally. no nasal discharge only facial soreness. Buttock much better.
8-10/10/42.	Continue basal douches and dressings.	Buttock now dry and clean nose clear. Appear to be convalescing well.
11.10.42.	[illegible]: Coramine 1.7 cc. Strychnine 1/30 gr. Lying absolutely flat not moving. Fluids only. Mineral oil.30 nocte. [illegible] Strychnine gr. 1/30 Coramine 1.7 cc.	Acute Cardiac Attack. With tachycardia (190) cyanosis very marked breathlessness and clothing and vomiting condition unchanged.
12.10.42.	Coramine 9 a.m. Camphor in oil 2 cc 12 noon. Strychnine gr. 1/30 1 P.M.	Repeated attacks of acute Dyspnoea cyanosis extreme Died 1.40 P.M.

CASE NO.		NAME OF DIAGNOSING DOCTOR	DOCTOR	C. C. Gray. Jr.			
UNIT.	M. G.	NATIONALITY	Canadian.	NAME AND RANK.	Pte. Nichol D. S.		
NAME OF DISEASE	Acute Enteritis.			DATE ADMITTED	9.10.42.	DATE DISCHARGED.	Died:- 12.10.42.

DATE.	TREATMENT.	REMARKS.
9.10.42.	History :- Severe diarrhoea and cramps for 2 days prior to admission. 40 Bowel movements in 24 hours. Stool : contains blood and mucous.	
	Mag. Sulph. 4.0 gm. f.2.h. x 4. - fluids.	
10.10.42.	Mag. Sulph. 4.0 gm. f.2.h. x 2. - fluids	30 movements in last 24 hours. Cramps same. Patient weak and toxic.
11.10.42.	Light diet.	12 movements in last 24 hours. Cramps worse. Still passing only blood and mucous. Patient appears quite shocked. Cold, clammy sweat, pulse feeble. Prognosis bad.
12.10.42.		Died 6.00 A.M.

Capt. G.C. Gray Jr.

CASE No:		NAME OF DIAGNOSING DOCTOR		Captain S. M. Banfill.			
UNIT.	Royal Rifles of Canada.	NATIONALITY	Canadian.	NAME AND RANK	Rfn: Bunyluk, Nickolas.		
NAME OF DISEASE	DIPHTHERIA Faucial & Laryngeal.		DATE ADMITTED	Oct/2/42	DATE DISCHARGED	Died. Oct/12/42	

DATE	TREATMENT.	REMARKS.
Oct/2.	Hot Potassium Permanganate Gragles f.2.h.	Admitted with right tonsil covered with membrance R(+/0)L
Oct/3.	Gargles. f.2.h.	Membrance extends to left tonsil. R(++/+L)
Oct/4.	Gargles. f.2.h.	Rapid extension of disease with swelling cervila membrance. (R++++/L+)
Oct/5.	Gargles. f.2.h.	Condition unchanged.
Oct/6.	Gargles. f.2.h.	Much swelling and extension to cervila membrance. (R++++/L+)
Oct/7.	Gargles. f.2.h.	Membrance. (R+++/L+++)
Oct/8.	Gargles. f.2.h.	Membrance unchanged Cervical glandular enlargement noticeable.
Oct/9.	Gargles. f.2.h.	Conditon critical. Heart poor, Membrance. (R+++/L++++)
Oct/10	Gargles. f.2.h.	Condition unchanged except for increased strides due to probable laryngeal involvement.
Oct/11	"	Practically moribund great respiratory difficulty.
Oct/12	No Antitoxin was available for this case.	Died at 2.30.A.M.

Sgd: S.M.Banfill.
Captain.

CASUALTY		NAME OF DIAGNOSING DOCTOR	Capt. J.A.G. Reid		
UNIT	The Roy al Rifles of Canada	NATIONALITY	Canadian	NAME AND RANK	VERMETTE, Patrick Corporal
NATURE OF DISEASE	Acute Enteritis	DATE ADMITTED	9/10/42	DATE DISCHARGED	16/10/42

DATE	TREATMENT	REMARKS
Oct. 9	Mag. Sulph. ℥ ss q 2 h. x 4 Fluid diet	Severe diarrhoea - 30 times in 24 hours.
Oct. 10	Fluid diet	Severe diarrhoea. Greenish, mucopurulent stools.
Oct. 11	Fluid diet	Stools somewhat less frequent. Patient quite weak.
Oct. 12	Light diet. Push fluids	15 stools in 24 hours Patient very weak.
Oct. 13	Fluid diet. Sedative mixture every three hours, for four doses. Heat to belly and feet	Patient had repeated vomiting with recrudescence of diarrhoea. A very bad day and very weak tonight.
Oct. 14	Light diet. Push fluids	Patient slightly better to-day. Vomiting controlled. Diarrhoea less frequent. Very weak still.
Oct. 15	Light diet. Push fluids. Heat to body	Condition unchanged Patient remains in a state of partial circulatory collapse.
Oct. 16	Light diet. Push fluids.	Patient remained as before. Unable to take much nourish-ment. Pulse weak. Died at 3:00 P.M.

Cause of Death - Acute Enteritis

H.A.G. Reid
Capt.

CASE NO. 677

No.	3361		Name of Diagnosing Doctor		N.B. Pasary Jemadar, I.M.D.
Unit	H.A.S.R.A.	Nationality	Indian	Rank	Gunner (age:30 yrs)
				Name	Allah Yar
Name of Disease	Dysentery Amoebic & Bacilary	Date Admitted	4.9.42	Date Discharged	Died at 15.35 hours on 16.10.42.

Date	Treatment	Remarks
4.9.42	Frequency of stools 25 times in 24 hours containing blood and mucus associated with pain in the abdomen. Duration two months. Patient is weak and emaciated. Stool for exam. Exudate Bacilary ++ Patient is semi-conscious and passing motions involuntarily. Pulse is very feeble (5 p.m.)	
5.9.42.	Stools - 20 times, liquid in consistency, blood + mucus ++ Moderate temperature, pain in the abdomen ++ and passing motions involuntarily.	
6.9.42	Stools - 15 times, liquid in consistency, blood + mucus ++ temp 100°F, pain in the abdomen ++, patient is conscious.	
7.9.42	Stools - 15 times, blood + mucus - less, liquid in consistency. Pain in the abdomen less..	
8.9.42	Stools - 8 times, liquid in consistency, blood & mucus - trace, pain in the abdomen - nil.	
9.9.42	Stools - 4 times, semi solid, blood + mucus trace, pain nil. Patient cannot swallow.	
10.9.42	Stool for Examn. E. H. + + .	
14.9.42	No improvement. Patient complains of loss of appetite. Soreness of the throat ++.	
19.9.42	Condition is worse day by day.	
24.9.42	Patient cannot take any food; there is no appetite, bowels moved 4 times without blood & mucus.	
30.9.42	Stools - 4 times, liquid in consistency and without blood and mucus, Herpes on both the lips and angles of the mouth, throat congested and there is pain during deglutition. Patient is extremely weak and emaciated.	Milk - 1 bottle daily
4.10.42	Stool for Examn. E.H. + + Stools - 6 times without blood and mucus, liquid in consistency. Patient can not move. Condition of the lips and the angles of the mouth better.	
8.10.42.	Condition is not satisfactory. Passed 6 motions. Lips are alright now. Patient can not move from side to side.	
12.10.42	Condition is getting worse day by day.	
16.10.42	Patient expired at 15.35 hours.	

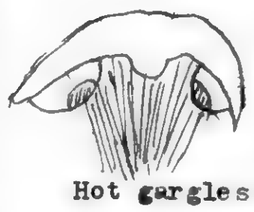
N.B. Pasary,
Cheton Dev,
Jemadar, I.M.D.
Commanding Bai Ki Dhanda Sho.

CASE NO.		NAME OF DIAGNOSING DOCTOR	DOCTOR	Capt. S.M. Banfill	
UNIT	The Winnipeg Grenadiers	NATIONALITY	Canadian	NAME AND RANK	EASTHOLM, Eric Private
NATURE OF DISEASE	1. Malnutrition 2. Avitaminosis 3. Diphtheria, Faucial	DATE ADMITTED	3/10/42	DATE OF DEATH	Died 16/10/42

	TREATMENT	REMARKS
Oct. 3	Hot compresses q.2 h. to right hand and foot. Potassium Permanganate dressings to perianal regionsand scrotum q.2 h.	Extremely emaciative person with:1. Severe pains in legs; 2. Infection, rt. hand superficial. 3. Infection, rt. foot superficial. 4. Ulceration, perianal and scrotal.
Oct. 5	Treatment as above.	Slight improvement in hand and foot. Marked Anorexia.
Oct. 7	As above	Condition unchanged
Oct. 10	As above	Improvement very slow. Complains of complete loss of appetite.
Oct. 13	As above for skin infectbns. Anti-toxin 2000 units	No change in skin lesions. Complains of sore throat. Fairly extensive diphtheric membrane on right tonsil. R(++/0)4
Oct.14	Hot compresses. Pot. Permang. dressings and gargles q. 2 h.	No extension of membrane but seems very weak.
Oct. 15	As above	Throat improving R(+/0)4
Oct. 16	As above	Not eating. Infections painful. Seems dehydrated. Throat clear. Died at 8:45 P. M.

Eric Banfill Capt

CASE NO		NAME OF DIAGNOSING DOCTOR		Capt. G.C. Gray, Jr.		
UNIT	The Winnipeg Grenadiers	NATIONALITY	Canadian	NAME AND RANK	FORBES, James Philip Private	
NATURE OF DISEASE	Diphtheria - Nasal - Faucial	DATE ADMITTED	30/9/42	DATE DISCHARGED	Died 16/10/42	

	TREATMENT	REMARKS
Sept.30	 Hot gargles q. 2. h.	Sore throat for 10 days becoming worse 4 days before admission. Deglutition difficult. Both nostrils have membrane, also present on thetonsils and post. pharyngeal wall.
Oct. 2	Hot gargles q. 2 h.	Membrane more extensive Bilateral cervical adenitis.
Oct. 4	 Hot gargles q. 2 h.	Bilateral deafness. Post. pharyngeal wall covered with membrane
Oct. 6	Hot gargles q. 2 h. Pot. Permang. compresses to elbos and hips	Less membrane. Very toxic. Developing decubitus ulcers on elbows and hips. Very weak.
Oct. 8	Treatment as before	Profuse, foul nasal discharge. Prognosis grave.
Oct. 10	" " "	Condition same.
Oct. 12	" " "	Increased nasal and post-nasal discharge. No improvement.
Oct. 14	" " "	Pulse weak, irregular in rate and rhythm
Oct. 16	" " "	Patient delirious 12 hours ago. Moribund for several hous before death at 3:30 P.M.

(Capt. Accre).

NAME OF DIAGNOSING DOCTOR: Capt. J.A.G. Reid

UNIT: The Royal Rifles of Canada | NATIONALITY: Canadian | NAME AND RANK: CORMIER, Leo Abbey, Rifleman

DISEASE: Acute Grastro-Enteritis | DATE ADMITTED: 14/10/42 | DATE OF DEATH: Died 16/10/42

	TREATMENT		REMARKS
Oct. 14	Mag. Sulph.	q. 1 h. x 6 Fluid diet	Patient had 24 hours of acute diarrhoea without blood and this continued after admission.
Oct. 15	Fluid diet.	Heat to belly.	Patient continued to have sharp diarrhoea. During the night he developed marked bilious vomiting and passed a poor night.
Oct. 16	Fluid diet.	Heat to belly	Patient was weak and toxic, anxious and slightly feverish. Vomiting was fairly well controlled by sedative and diarrhoea decreased. However, patient suddenly collapsed and died at 9:30 P.M.

Cause of death - Acute Gastro-Enteritis

J.A.G. Reid. Capt

CASE		NAME OF DIAGNOSING DOCTOR	Capt. S.M. Banfill		
UNIT	Royal Rifles of Canada	NATIONALITY	Canadian	NAME AND RANK	CHENELL, John Maxwell Lance-Corporal
THE CASE	1. Diphtheria, Faucial 2. Acute Enteritis	DATE ADMITTED	4/10/42	DATE DISCHARGED	Died 16/10/42

	TREATMENT	REMARKS
Oct. 4	Pot. Permanganate gargles q. 2 h.	Admitted as a suspected diphtheria with follicular tonsillitis. Considerable swelling of throat tissues.
Oct.5.	Pot. Permanganate gargles	Diphtheria definite. Membrane on both tonsils. R (+/+) L
Oct.6	Gargles q 2 h.	Membrane unchanged
Oct.7	Gargles q 2 h.	Membrane R(++/+)L
Oct.8, 9	Gargles q 2 h.	Condition unchanged
Oct. 10	Gargles q 2 h.	Membrane subsiding
Oct. 12	Gargles q 2 h.	Swelling of throat less. Only follicles to be seen on tonsils
Oct. 13	Gargles q 2 h.	Follicles on right side only
Oct. 14	Gargles q 2 h.	Condition good
Oct. 15	Gargles - Moved to room next to latrines. Fluid diet	Had diarrhoea during night but improved in morning. Pulse very fast and feeble. Became breathless, diarrhoea became frequent in evening. Died at 1:00 A.M.

S.M. Banfill Capt.

CASE		NAME OF DIAGNOSING DOCTOR	DOCTOR	Capt. G.C. Gray, Jr.	
UNIT	The Royal Rifles of Canada	NATIONALITY	Canadian	NAME AND RANK	MULLIN, Elmer Owen Rifleman
DISEASE	Diphtheria, Nasal	DATE ADMITTED	3/10/42	DATE OF DEATH	Died 7:30 A.M. 17/10/42

TREATMENT

Oct. 3	Admitted with rather extensive infected superficial sores, especially about the feet and legs, arms and hands, and buttocks. Treatment: Moist pot. permang. compresses q. 2 h. x 6	
Oct. 4	 Hot gargles q. 2 h. Hot fomentations to skin lesions.	Developed sore throat. Membrane over both tonsils. Nose plugged on both sides.
Oct. 6	Hot gargles q. 2 h. Moist pot. permang. compresses q. 2 h	No membrane in throat. Nose has membrane on both sides.
Oct. 8	Nasal irrigation. Warm pot. permang. q. 2 h. Moist pot. permang. compresses q. 2 h. x 6	No change
Oct.10	Same treatment	Mucopurulent discharge from nose. Skin lesions show no improvement
Oct. 12	Treatment as before.	Condition same
Oct. 14	" " "	Patient looks very pale. Feels weak. Pulse regular, 80, but not of good quality.
Oct. 16	" " "	Weaker. Nose unchanged. Toxic.
Oct. 17	" " "	Patient died suddenly at 7:30 A.M. J.C. Gray Jr. Capt. RCAMC

CASE NO		NAME OF DIAGNOSING DOCTOR	DOCTOR	Capt. G.C. Gray	
UNIT	W.G.	Hospital	Canadian	NAME AND RANK	LA PLANTE, Roman Joseph Private
DATE OF ONSET	Acute Enteritis		DATE ADMITTED	6/10/42	DATE DISCHARGED: Died 17/10/42 6:45 P.M.

	TREATMENT		REMARKS
Oct.6	Admitted to General Hospital with N.Y.D. Pharyngitis. This progressed favorably with treatment but an attack of acute diarrhoea with passage of blood and mucous supervened and he was transferred to the Dysentery Ward on Oct. 9.		
Oct. 9	Liquid diet.		Patient extremely emaciated and weak.
Oct.10	Mag. sulph. 4 gm. q. 2 h. x 2.	Liquid diet.	25 bowel movements in 24 hours. Cramps present. Blood and mucous in stool.
Oct.11	Light diet		18 bowel movements in 24 hours
Oct.12	" "		Fewer movements but patient very weak. Prognosis bad.
Oct.14	" "		Blood again in stool. Increase in bowel movements.
Oct.16	" "	Bis. sal. gr.xxx q. 2 h. x 4.	Very toxic. Pulse fast and thready. Considerable cramps.
Oct.17	" "	Morph.sulph. gr. 1/6 4:00 P.M.	Patient moribund nearly all day. Died at 6:45 P.M.

00395

SHEET 2.

Case No		Name of Diagnosing Doctor	Major A.P. Brown, R.A.M.C.		
Unit.	H. Sc tr.	Nationality	British.	Name and Rank.	Pte. C. Y[illegible], P.T.R. [illegible]. Age 27 yrs.
Name of Disease	Fracture [illegible] Post Di[illegible]	Date Admitted	25/9/42	Date Discharged	DIED 30/10/42 2 p.m.

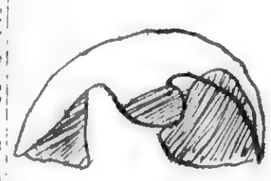
DATE	TREATMENT	REMARKS
30/9/42	C.T.	Some in[illegible] f.d. L[illegible] - in[illegible]. P 90. [illegible] slightly [illegible].
2/10/42	C.T.	C/a [illegible] Sleeps well. Some [illegible]
4/10/42	C.T.	C/a di[illegible] - left [illegible]
6/10/42	C.T.	P 100.
7/10/42	C.T.	
10.10.42	C.T.	
[illegible]	C.T.	
[illegible]	At[illegible] 1/100th.	
[illegible]	[illegible] 1/100th.	
[illegible]	[illegible] 1/100th h.i.d.	
[illegible]	[illegible] 1/100th h.i.d.	
[illegible]	At[illegible] 1/100 [illegible].	

CAUSE OF DEATH : [illegible]

M.P. Brown

[illegible], R.A.M.C.

CASE NO.		NAME OF DIAGNOSING DOCTOR	DOCTOR	Capt. G.C. Gray Jr.		
UNIT	Royal Rifles of Canada	NATIONALITY	Canadian	NAME AND RANK	McARA, William Roger Rifleman	
NATURE OF DISEASE	Diphtheria, Faucial	DATE ADMITTED	3/10/42	DATE DISCHARGED	Died 19/10/42 11:45 P.M.	

DATE	TREATMENT	REMARKS
Oct.3	Admitted with history of sore throat for 24 hours.  Hot gargles q. 2 h.	Membrane over both tonsils. No cervical adenitis
Oct.5	" " "	No change
Oct.7	" " "	Increase in membrane left side to-day with an enlarged cervical gland on that side.
Oct. 9	 Hot gargles q. 2 h.	Marked increase in membrane. Uvula now included.
Oct. 11	" " "	Throat appears the same. Patient appears quite toxic. Pulse fast and irregular
Oct. 13	 " " "	Less membrane. Palatal paralysis. Left cervica l adenitis less. Still very toxic. Condition Fair.
Oct. 15	" " "	Membrane the same. Heart sounds not of good quality. Pulse 90 still somewhat irregular
Oct.17	" " "	Throat unchanged. Patient vomiting all food. Very weak. Condition poor.
Oct.19		Patient died at 11:45 P.M. (Capt. [illegible])

CASE NO		NAME OF DIAGNOSING DOCTOR		DOCTOR	Capt. J.A.G. Reid		
UNIT	The Royal Rifles of Canada	NATIONALITY	Canadian	NAME AND RANK	THOMSON, John Alexander Rifleman		
NAME OF DISEASE	1. Acute Enteritis 2. Malnutrition	DATE ADMITTED	16/10/42	DATE DISCHARGED	Died 21/10/42		

DATE	TREATMENT	REMARKS
Oct.16	Mag. Sulph. ℥ss q. 1 h. x 4 Fluid diet	Patient admitted complaining of mild diarrhoea and amblyopia, the latter of sudden onset and of former occurrence with complete recovery, this thought to be of a functional nature. He was emaciated and weak.
Oct.17	Fluid diet. Heat to belly	Sharp diarrhoea this day. Vision normal. Patient weak.
Oct.18	Light diet. Bismuth ℥ss q. 2 h. x 4	Patient continues to have sharp diarrhoea with marked anorexia and slight nausea. Very weak.
Oct.19	Full diet. Bismuth ℥ss q. 2 h. x 4	Sharp diarrhoea persists. Slight vomiting. Unable to retain any nourishment. Very weak.
Oct.20	Full diet. Bismuth ℥ss q. 2 h. x 4	Patient going rapidly downhill. Persistent vomiting and diarrhoea
Oct.21	Full diet. Bismuth ℥ss q. 2 h. x 6	Condition unchanged. Moribund. Died at 10:00 P.M.

Cause of Death - (1) Acute Enteritis
(2) Malnutrition

H.G. Reid, Capt (RCAMC)

CASE NO		NAME OF DIAGNOSING DOCTOR	DOCTOR	Capt. G.C. Gray Jr.	
UNIT	The Winnipeg Grenadiers	NATIONALITY	Canadian	NAME AND RANK	HOWARD, H.S. Private
NAME OF DISEASE	Acute Enteritis	DATE ADMITTED	17/10/42	DATE DISCHARGED	Died 22/10/42 8:40 P.M.

DATE	TREATMENT	REMARKS
Oct.17	Admitted with history of severe diarrhoea and cramps accompanied by two attacks of vomiting in 24 hours prior to admission. Cramps were very severe and stool consisted of only blood and mucous. Castor Oil 1 oz. at 11:00 A.M. Trianon 4 cc. intramuscularly at 4:30 P.M. Trianon 2 cc. intramuscularly at 10:00 P.M.	
Oct.18	Trianon 2 cc. intramuscularly at 10:00 A.M.	30 movements in 24 hours. Cramps still severe. Vomited twice.
Oct.19	Soda bicarb. 1 oz. at 10, 2, 6 Push fluids.	Diarrhoea much less. Cramps not as severe.
Oct.20	Bic. Sal. 1 oz. at 12, 4, 8	10 movements in 24 hours. No cramps. Improved.
Oct.21	Bic. Sal. 1 oz. at 10, 2, 6	Patient had hiccoughs all last night and less frequently to-day. Against orders, repeatedly made himself vomit to relieve this and consequently to-night is quite dehydrated and weak.
Oct.22	Fluids	Still has hiccoughs and still vomiting. Very weak. Condition poor. Died at 8:40 P.M. Capt. G.C. Gray

Case No		Name of Diagnosing Doctor	R. L. Lancaster.		
Unit	8th. Coast. R.A.	Nationality	British.	Name and Rank.	PETTITT, Frank, B.Q.M.S.
Name of Disease	Malnutrition.	Date Admitted	27.9.42.	Date Died ~~Discharged~~	22.10.42. 5.05.p.m.

DATE	TREATMENT	REMARKS
27.9.42.		No appetite. Neuralgia of feet. Diarrhoea. Anaemia. Emaciation. Tachycardia. Pulse 112. T.99.2.
28.9.42.	Chloral nocte.	
30.9.42.		
3.10.42.	Aspirin.	
5.10.42.	Blaud's Pills lV. t.d.s.	
6.10.42.		Failing vision,
7.10.42.	Thiamine injections. 2 c.c. alt die.	Oedema of ankles.
14.10.42.	Injection Emetine grs ½ daily.	Stool: Cysts of Entamoeba Histolytica.
16.10.42.		Pulmonary Systolic Murmur. Apex - Nipple Line. P.108.
18.10.42.	Sodii Salicyl grs.X t.d.s. Cod Liver Oil 1 oz t.d.s.	c/o pains in left thigh.
21.10.42.	Ferri et Ammon. Cit. grs. XV t.d.s. Inj. Hepatax intravenously.	Condition failing. Pulse poor; circ.120.
22.10.42.	Inj. Coram ne intravenously. Inj. Adrenalin (intracardiac).	Sudden Cardiac failure with Hyperpnoea at 4.55. p.m. Died at 5.05 p.m.

R Kaucilce Capt.

Pettitt B.Q.M.S. R.A. Rangoon

Pettitt Frank.

00408

CASE NO		NAME OF DIAGNOSING DOCTOR	DOCTOR	Capt. G.C. Gray Jr.	
UNIT	The Royal Rifles of Canada	NATIONALITY	Canadian	NAME AND RANK	PATTERSON, J.R. Rifleman
NAME OF DISEASE	Acute Enteritis	DATE ADMITTED	15/10/42	DATE DISCHARGED	Died 23/10/42 3:00 A.M.

DATE	TREATMENT	REMARKS
Oct.15	Admitted to general hospital 15/10/42 with brisk diarrhoea. No blood in stool at this time. No previous dysentery. Was treated with mag. sulph ½ oz. q. 1 h. x 4 and fluid diet. Had continued frequent motions without abatement and accompanied by moderate cramps. Had fever on 18/10/42 and blood and mucous appeared in stool the next day. He was transferred to Dysentery Ward on 19/10/42.	
Oct.19	Tranon 4 cc. intramuscularly 9:00 P.M.	40 movements in last 24 hours. Cramps
Oct. 20	Trianon 2 cc. intramuscularly 11:00 A.M. Trianon 2 cc. " 9:00 P.M.	24 movements in last 24 hours. Still blood and mucous. Patient very uncooperative. condition only fair.
Oct.21	Mist. Brom. et Chloral ½ oz. 10, 2, 6	Still frequent stools Very toxic. Increasing weakness. Pulse of poor quality
Oct.22	Heat to abdomen. Morph. Sulph. gr. ¼, 5:00 P.M.	Complains of severe Pain in mid-abdomen. Extremely restless. Condition poor.
Oct.23	Died at 3:00 A.M.	(Capt. R.C.A.M.C.)